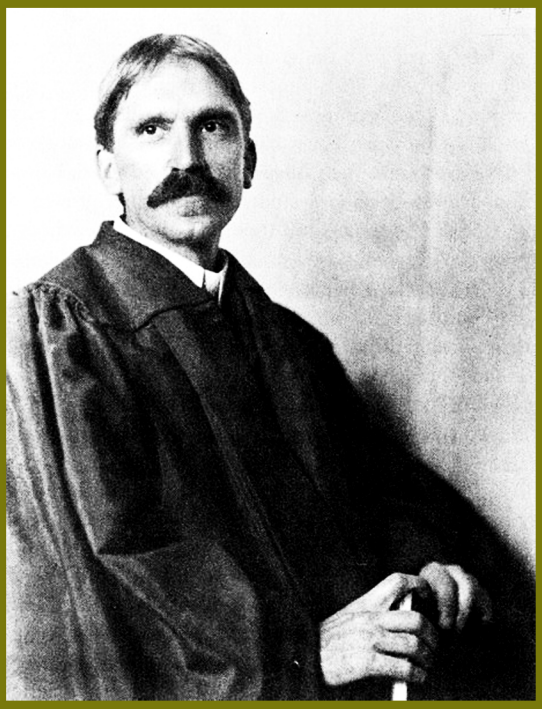
No. 2 www.ijip.in | ISSN 2348-5396

Volume: 2 Issue 1 October-December:2014

The International Journal of INDIAN PSYCHOLOGY

Person of the Issue



John Dewey (1859-1952)

Editor in Chief:
Dr. Suresh M. Makvana
Editor:
Mr. Ankit P. Patel

ISSN 2348-5396
9 772348 539009

e-Inde

The International Journal of
INDIAN PSYCHOLOGY

Volume 2, Issue 1, No. 2

October to December 2014

Editor in Chief

Dr. Suresh M. Makvana

Co-Editor

Mr. Ankit P. Patel

THE INTERNATIONAL JOURNAL OF INDIAN PSYCHOLOGY

This Issue (Volume 2, Issue 1, No. 2) Published, October 2014

Headquarters;

REDSHINE Publication, 88, Patel Street, Navamuvada, Lunawada, Gujarat, India, 389230

Customer Care: +91 99 98 447091

Copyright © 2014, IJIP

No part of this publication may be reproduced, transcribed, stored in a retrieval system, or translated into any language or computer language, in any form or by any means, electronic, mechanical, magnetic, optical, chemical, manual, or otherwise, without the prior written permission of RED'SHINE Publication except under the terms of a RED'SHINE Publishing Press license agreement.

ISSN (Online) 2348-5396

ISSN (Print) 2349-3429

Price: 299 INR/- | $ 1.67 USD

2014 Edition

Website: www.ijip.in

Email: info.ijip@gmail.com | journal@ijip.in

Please submit your work's abstract or introduction to (info.ijip@gmail.com | www.ijip.in)

Publishing fees, 500 INR OR $ 8.33 USD only (online and print both)

The Editorial Board is comprised of nationally recognized scholars and researchers in the fields of Psychology, Education, Social Sciences, Home Sciences and related areas. The Board provides guidance and direction to ensure the integrity of this academic peer-reviewed journal.

Editor-in-Chief :

Dr. Suresh M. Makvana, INDIA
Associate Professor. Dept. of Psychology, Saradar Patel University. Vallabh Vidhyanagar, Gujarat,
Chairman, Board of Study, Sardar Patel University, Gujarat State

Editor :

Mr. Ankit Patel, INDIA
Author of 20 Psychological Books (National and International Best Seller), Sardar Patel University, Gujarat.

Editorial Advisors :

Dr. John Michel Raj. S, INDIA
Dean, Professor, Dept. of Social Science, Bharathiar University, Coimbatore, Tamilnadu.

Dr. Tarni Jee, INDIA
President, Indian Psychological Association (IPA)
Professor, Dept. of Psychology, University of Patana, Patana, Bihar.

Prof. C. R. Mukundan, PhD, D.M & S.P
Professor Emeritus/Director
Institute of Behavioral Science, Gujarat Forensic Sciences University, Gandhinagar, Gujarat,
Author of "Brain at Work"

Co-Editor(s):

Dr. Samir J. Patel, INDIA
Head, Professor, Dept. of Psychology, Sardar Patel University, Vallabh Vidhyanagar, Gujarat.

Dr. Navin Patel, INDIA
Convener, Gujarat Psychological Association (GPA)
Head, Associate Professor, Dept. of Psychology, GLS Arts College, Ahmadabad, Gujarat,

Dr. Mahepat Shinh Chavada INDIA
Chairman, Board of Study, Gujarat University, Gujarat State
Principal, L. D Arts College, Ahmadabad, Gujarat

Dr. M. G. Mansuri, INDIA
Head, Associate Professor, Dept. of Psychology, Nalini Arts College, Vallabh Vidhyanagar, Gujarat,

Dr. D. J. Bhatt,
Head, Professor, Dept. of Psychology, Saurashtra University, Rajkot, Gujarat, INDIA

Dr. Ashvin B. Jansari,
Head, Dept. of Psychology, Gujarat University, Ahmadabad, Gujarat, INDIA

Dr. Savita Vaghela, INDIA
Head, Dept. of Psychology, M. K. Bhavanagar University, Bhavnagar, Gujarat,

Dr. Bharat S. Trivedi, INDIA
Head, Associate Professor , Dept. of Psychology, P. M. Pandya Arts, Science, Commerce College, Lunawada, Gujarat,

Editorial Assistant(s):

Dr. Raju. S, INDIA
Associate Professor , Dept. of Psychology, University of Kerala, Kerala,

Dr. Sangita Pathak
Professor , Dept. of Psychology, Sardar Patel University, Vallabh Vidhyanagar, Gujarat INDIA

Dr. Karsan Chothani
Head, Associate Professor , Dept. of Psychology, C. U. Shah College, Ahmadabad, Gujarat, INDIA

Dr. R. B. Rabari, INDIA
Head, Associate Professor, SPT Arts and Science College, Godhra, Gujarat,

Dr. Yogesh Jogasan, INDIA
Associate Professor, Dept. of Psychology, Saurashtra University, Rajkot, Gujarat,

Dr. Shailesh Raval, INDIA
Associate Professor, Smt. Sadguna C. U. Arts College for Girls. Lal Darwaja, Ahmedabad, Gujarat.

Dr. Thiyam Kiran Singh,
Assistant Professor, Dept. of Psychology, AIBAS, Amity University, Rajasthan, INDIA

Dr. Ravindra Kumar,
Assistant Professor, Mewar University, Chittorgarh, Rajasthan, INDIA

Dr. Milan P. Patel,
Physical Instructor, College of Veterinary Science and A.H., Navsari Agricultural University, Navsari, Gujarat, INDIA

Mr. Yoseph Shumi Robi
Assistant Professor. Department of Educational Psychology, Kotebe University College, Addis Ababa, KUC, ETHIOPIA

Dr. Pankaj Suvera,
Assistant Professor. Department of Psychology,Sardar Patel University, Vallabh Vidhyanagar, Gujarat, INDIA

Dr. Ali Asgari,
Assistant Professor. Department of Psychology, Kharazmi University, Somaye IRAN

St., Tehran,
Dr. Ajay K. Chaudhary,
Senior Lecturer, Department of Psychology, Government Meera Girls College, Udaipur (Raj.) — INDIA
Dr. Priyanka Kacker,
Assistant Professor, Neuropsychology and Forensic Psychology at the Institute of Behavioral Science, Gujarat Forensic Sciences University, Gandhinagar, Gujarat,

Reviewer(s):
Ms. Lexi Lynn Whitson
Senior Researcher, West Texas A&M University, Canyon, — UNITED STATES
Ms. Rūta Gudmonaitė
Project Manager, Open University UK, Milton Keynes, England, — UNITED KINGDOM
Mr. Mark Javeth
Research Assi. Tarleton State University, Stephenville, Texas, — UNITED STATES

Online Editor(s):
Mr. Ansh Maheta,
Clinical Psychology, Sardar Patel University, Vallabh Vidhyanagar, Anand, Gujarat, — INDIA

Message from Editorial Board

The journey from October 2013 to October 2014 has been really amazing. Our experience so far has been extremely rewarding and we got to know many knew writers, researchers and their creations. We received a lot of love from readers and writers for our Volume 1 of the journal. Due to your overwhelming response the International Journal of Indian Psychology was chosen in a survey by the Directory of Science to be ranked among many other such academic journals and we received a score of 19.67; claiming the first position of all the other journals throughout the world. For this, the IJIP team cannot thank you enough.

Now IJIP has entered its second phase. This includes the beginning of the Volume 2. With the change in Volume, some of the policies of our journal and its format have also changed a bit. We hope that these changes are up to your expectations and that they will not disappoint you.

We wish to congratulate all the people who have published their literature in the Volume 2, Issue 1, no. 2. We hope that your experience with IJIP has been fruitful and worthwhile.

Furthermore we would like to address the readers that the upcoming issues will contain a lot more literature for which you have been waiting for so long.

Thanking one and all,

Dr. Suresh Makvana,

Mr. Ankit Patel

And whole Team

Index of Volume 2, Issue 1, No.2

Disclaimer

The views expressed by the authors in their articles, reviews etc in this issue are their own. The Editor, Publisher and owner are not responsible for them. All disputes concerning the journal shall be settled in the court at Lunawada, Gujarat.

The present issue of the journal is edited & published by RED'SHINE Publication (A unit of RED'MAGIC Networks. Inc) at 86/Shardhdha, 88/Navamuvada, Lunawada, Gujarat-India, 389230

Copyright Notes

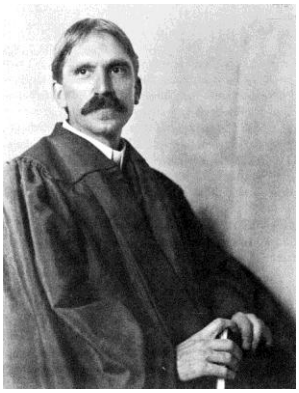
© 2014; IJIP Authors; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

w w w . i j i p . i n

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B002TV2I12014
http://www.ijip.in | Oct to Dec 2014

Person of the Issue: John Dewey (1859-1952)

Ankit Patel*



Born	October 20, 1859 Burlington, Vermont, United States
Died	June 1, 1952 (aged 92) New York, United States
Alma mater	University of Vermont, Johns Hopkins University
Religion	Western Philosophy
Era	20th-century philosophy
School	Pragmatism
Main interests	Philosophy of education, Epistemology, Journalism, Ethics

John Dewey (October 20, 1859 – June 1, 1952) was an American philosopher, psychologist, and educational reformer whose ideas have been influential in education and social reform. Dewey is one of the primary figures associated with philosophy of pragmatism and is considered one of the founders of functional psychology. A well-known public intellectual, he was also a major voice of progressive education and liberalism. Although Dewey is known best for his publications about education, he also wrote about many other topics, including epistemology, metaphysics, aesthetics, art, logic, social theory, and ethics.

John Dewey graduated from the University of Vermont and spent three years as a high school teacher in Oil City, Pennsylvania. He then spent a year studying under the guidance of G. Stanley Hall at John Hopkins University in America's first psychology lab. After earning his Ph.D. from John Hopkins, Dewey went on to teach at the University of Michigan for nearly a decade.

In 1894, Dewey accepted a position as the chairman of the department of philosophy, psychology and pedagogy at the University of Chicago. It was at the University of Chicago that Dewey began to formalize his views that would contribute so heavily to the school of thought known as pragmatism. The central tenant of pragmatism is that the value, truth or meaning of an idea lies in its practical consequences. Dewey also helped establish the University of Chicago Laboratory Schools, where he was able to directly his apply his pedagogical theories.

Dewey eventually left the University of Chicago and became a professor of philosophy at Columbia University from 1904 until his retirement in 1930. In 1905, he became President of the American Psychological Association.

*MA, Clinical Psychology, Dept. of Psychology, Sardar Patel University, Vidhyanagar, Gujrat

© 2014 A Patel; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

Dewey's work had a vital influence on psychology, education and philosophy and he is often considered one of the greatest thinkers of the 20th-century. His emphasis on progressive education has contributed greatly to the use of experimentation rather than an authoritarian approach to knowledge. Dewey was also a prolific writer, publishing numerous books and articles on a wide range of subjects including education, art, nature, philosophy, ethics and democracy over his 65-year writing career.

TIME LINE

1. October 20, 1859 - John Dewey born at 186 South Willard Street, Burlington, Vt. His father, Archibald Sprague, was thriving in the grocer business and his mother Lucina Artemisia Rich was a devote Christian.
2. November 24, 1859 - Charles Darwin publishes *On the Origin of the Species*. In 1910 Dewey would publish the influential text, *Influence of Darwin on Philosophy and Other Essays*. New York: Henry Holt and Company (1910).
3. 1865 - Lee surrenders to Grant at Appomattox Court House on April 9, 1865, ending the Civil War. The 13th Amendment ends slavery.
4. 1879 - After studying with H.A.P. Torrey, who mentored Dewey in moral philosophy, Dewey graduates from the University of Vermont, Phi Beta Kappa.
5. 1882 - Journal of Speculative Philosophy published Dewey's first articles; "The Metaphysical Assumptions of Materialism" and "The Pantheism of Spinoza." Dewey decides to make philosophy his life pursuit.
6. 1884 - Dewey graduates with a doctoral degree from John Hopkins University after studying with Charles S. Pierce and George Sylvester Morris.
7. 1884 - Dewey hired as Associate Professor at University of Michigan and works with George Morris on Hegelianism.
8. 1886 - Dewey marries Alice Chipman. Dewey takes the position of the Head of the Philosophy Department at the University of Chicago which included the disciplines of psychology and pedagogy.
9. 1894 Dewey's two and a half year old son Morris dies of diphtheria in Italy.
10. 1897 - Guglielmo Marconi takes the radio, his invention, to the Wireless Telegraph and Signal Company Ltd. in London.
11. 1899 - Dewey elected President of the American Psychological Association and The School and Society, which had been a series of lectures, was published.
12. 1902 - Dewey founds the school of education at the University of Chicago. The University elementary and high schools became known as the Laboratory Schools.
13. 1904 - Dewey leaves Chicago and takes the position of Professor of Philosophy and Lectureship in Psychology at Columbia University.
14. 1910 - William James, one of the great American philosophers of pragmatism, dies.
15. 1904 - Dewey's son Gordon dies at the age of eight of typhoid fever in Ireland.
16. 1912 - Dewey argues that women's suffrage is necessary to complete the democratic movement. Dewey addresses the summer students at Columbia on women's suffrage.
17. 1912 - Emperior P'u Yi steps down from the Dragon Throne of the Manchu's. Doctor Sun Yatsen helps lead the revolution which had begun the year before in Sichuan province.
18. 1914 - Archduke Franz Ferdinand assassinated leading to World War I.

The International Journal of INDIAN PSYCHOLOGY

19. 1915 - Dewey presents a series of lectures for the John Calvin McNair Foundation at the University of North Carolina in February under the title "German Philosophy and Politics."
20. 1918-1919 - Dewey takes a leave from Columbia University and spends the first half of the winter lecturing at the University of California. Dewey then travels with Alice to China and Japan.
21. 1918 - President Wilson announces his famous Fourteen Points to a joint session of Congress on January 8, 1918. His speech laid the groundwork for the end of WWI.
22. 1920 - Dewey lectures at the Imperial University in Tokyo and then at National University in Peking. The Chinese lectures, published in Chinese, are now available in an English: John Dewey: Lectures in China 1919 - 1920.
23. August 18, 1920 - the Nineteenth Amendment is ratified giving women the right to vote.
24. 1924 - Dewey travels to Turkey by the invitation of the Turkish government for educational system reform.
25. 1925 - Experience and Nature published and Dewey's metaphysical philosophy attempts to dissolve past mind/body dualities.
26. 1926 - Alfred Barnes takes Dewey along with a group of students to the museums of Madrid, Paris, and Vienna.
27. July 14, 1927 - Alice Dewey dies in New York City. During her life Alice had profound influence on Dewey's philosophy of education.
28. 1930 - Dewey retires from Columbia and named Professor Emeritus.
29. 1931 - Dewey's infant granddaughter dies. Additionally, George H. Mead dies. Mead and Dewey along with colleagues James H. Tufts, James R. Angell, and Edward Scribner Ames formed the core of the Chicago School of Pragmatism.
30. 1932 - Immigrant Adolf Hitler gains German citizenship. The German physicist Albert Einstein is granted a visa to the United States.
31. 1933 - Dewey works to socialize government programs during the Depression years.
32. 1933 - Franklin D. Roosevelt inaugurated president. Advent of New Deal politics.
33. 1934 - Art as Experience is published. Dewey dedicates the book to Alfred Barnes. Dewey's thirteen year old grandson dies.
34. 1935 - The John Dewey Society is founded, dedicated to the study of school and society. Dewey publishes Liberalism and Social Action, a product of a series of lectures given at the University of Virginia.
35. 1937 - Dewey endorsed the Neutrality Act thinking that war would delay his social programs.
36. 1937 - Leon Trotsky charged with sedition against Stalin. In exile, Trotsky requested an impartial hearing and the American Committee for the defense of Leon Trotsky was formed. Dewey presided over the hearing as Honorary Chairman.
37. 1939 - Dr. Tsume-ch Yu, Chinese Consul General bestowed upon Dewey and Nicholas Murray Butler of Columbia the decoration of the Order of the Jade.
38. 1939 - Dewey changes his mind on the war and realizes that totalitarianism was a grave threat to the survival of democratic institutions in Europe. He publishes, "Higher Learning and the War" (American Association of University Professors Bulletin (Dec, 1939).
39. 1940 - Dewey, joined by Alfred North Whitehead, William P. Montague, and Curt John Ducasse, defended the scholarship of Bertrand Russell in New York City.
40. 1941 - The United States enters WWII after the Japanese attack on Pearl Harbor.

The International Journal of INDIAN PSYCHOLOGY

41. 1945 - 1948 - Dewey works with Arthur F. Bentley on a cooperative venture resulting in a number of articles published in the "Journal of Philosophy."
42. 1945 - On August 6th and 9th, atomic bombs are dropped on Hiroshima and Nagasaki by the United States.
43. 1949 - Dewey's 90th birthday. Press releases from Canada, England, France, Holland, Denmark, Sweden, Israel, Mexico, Turkey, Japan, and India were sent to Dewey for his ninetieth birthday. Tributes to Dewey in the United States were extensive.
44. 1949 - The Soviet Union tests its first atomic bomb. William Faulkner wins the Nobel Prize for literature.
45. 1952 - Dewey dies of pneumonia at his apartment in New York City on June 1, 1952. Dewey cremated at Fresh Pond Crematory, Middle Village, Queens, NY.
46. 1952 - Sidney Hook publishes Some Memories of John Dewey.
47. 1965 - Official United States Dewey Stamp released commemorating the life and works of John Dewey.w

ACADEMIC AWARDS

- 1943: Copernican Citation
- 1946: Doctor "honoris causa" – University of Oslo
- 1946: Doctor "honoris causa" – University of Pennsylvania
- 1951: Doctor "honoris causa" – Yale University
- 1951: Doctor "honoris causa" – University of Rome

The International Journal of INDIAN PSYCHOLOGY

REFERENCE

1. Dewey, J. (1897). My Pedagogic Creed. *School Journal, 54*, 77-80.
2. Hickman, P. (2000). John Dewey. Muskingum College, Department of Psychology. Found online at http://www.muskingum.edu/~psych/psycweb/history/dewey.htm
3. Martin, Jay. (2003). *The Education of John Dewey.* Columbia University Press.
4. Neill, J. (2005). John Dewey, the Modern Father of Experiential Education. Wilderdom.com
5. The Center for Dewey Studies, Southern Illinois University Carbondale, http://deweycenter.siu.edu/about_bio.html

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00221V2I12014
http://www.ijip.in | Oct to Dec 2014

Conscientiousness among Call-Center Employees

Sonal D. Parmar*

ABSTRACT:

The aim of the present study was to find out the gender difference in conscientiousness and to study the impact of marital status difference in conscientiousness among call-center employees. The sample for the present study consisted of 200 call-center employees. 100 male employees (50 married & 50 unmarried) and 100 female employees (50 married & 50 unmarried). Call-center employees were selected randomly from various call-center of Vadodara city in Gujarat. Conscientiousness scale constructed by John, Donahue & Kentle, 1991; cited in John & Srivastava, 1999: 122, was used to measure conscientiousness trait among male/female and married/unmarried call-center employees. The data was analyzed in terms of mean, SD, and F-test. The result of F-test revealed significant difference in conscientiousness between male and female call-center employees. Male were conscientious than female call-center employees. Further analysis was carried out to know marital status effect on conscientiousness, result revealed no significant difference between married and unmarried call-center employees.

Keywords: *Conscientiousness, Gender, marital status, call-center.*

INTRODUCTION

The call center industry has exploded worldwide over the past two decades. Most people have had the experience of calling a call center, only to become frustrated or angry when the call center agent was unable to solve their problem, that's why call-center job is not an easy task. The work of a call center agent is seen as one of the ten most stressful jobs in the global economy (Holdsworth and Cartwright 2003). Employee stress also creates serious problems for companies and their customers. Personality types are important factors in determining stress, being able to explain how certain people manage to function for years while handling huge amounts of stress, whereas others collapse after several months under similar amounts of stress (Cooper 2005).Jonker (2004) found a negative relationship between stress and personality traits, particularly, conscientiousness was found to negatively correlate with job demands which lead to stress. So that researcher wants to find out conscientiousness level among call-center employees.

*Research scholar, M.A., B.Ed, M.Phil, G-SET, Department of Psychology Saurashtra University, India

© 2014 S Parmar; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

Conscientiousness is the personality trait of being thorough, careful, or vigilant. Conscientiousness implies a desire to do a task well. Conscientious people are efficient and organized as opposed to easy-going and disorderly. They exhibit a tendency to show self-discipline, act dutifully, and aim for achievement; they display planned rather than spontaneous behavior; and they are generally organized and dependable. It is manifested in characteristic behaviors such as being neat and systematic; also including such elements as carefulness, thoroughness, and deliberation (the tendency to think carefully before acting.) Individuals high in conscientiousness tend to be dutiful, self-disciplined, organized, ambitious, hardworking, persistent, efficient at carrying out tasks, and achievement orientated (Barrick & Mount, 1993; Spangler et al., 2004). Those low in conscientiousness tend to be easy-going, less exacting on themselves and others, negligent, disorganized, lazy and aimless (Barrick & Mount, 1993; Spangler et al., 2004).Conscientiousness is one of the five traits of the Five Factor Model of personality and is an aspect of what has traditionally been referred to as having character. Conscientious individuals are generally hard-working and reliable. When taken to an extreme, they may also be "workaholics", perfectionists, and compulsive in their behavior. People who score low on conscientiousness tend to be more laid back, less goal-oriented, and less driven by success; they also are more likely to engage in antisocial and criminal behavior. Looking at this aspect the present study was carried out with following

OBJECTIVES:

1. To find out the difference in conscientiousness level between male and female call-center employees.
2. To study the difference in conscientiousness level between married and unmarried call-center employees.
3. To find out the interaction effect of gender and marital status between call-center employees.

METHOD

Participants:

The Participants for the present study consisted of 200 call-center employees. 100 male employees (50 married & 50 unmarried) and 100 female employees (50 married & 50 unmarried). Call-center employees were selected randomly from various call-center of Vadodara city in Gujarat.

Instruments:

The following Instruments were employed in the present study:

Personal Data Sheet:

Personal data sheet was prepared to collect some personal information such as age, sex, whether they married or not etc.

Conscientiousness Scale:

In their assessment of measures of the Big-Five, John and Srivastava (1999) recommend using the Big Five Inventory (BFI) (John, Donahue & Kentle, 1991; cited in John & Srivastava, 1999: 122) as an efficient measure of the core attributes of the Big-Five. Conscientiousness was measured with the relevant nine-item scale. Responses were gathered on a 1 to 5 Likert-type scale with the respondent asked a set of sentences describing how they see themselves. For instance, a sample item for conscientiousness is *"Makes plans and follows them through".* Responses were 1. Strongly disagree; 2. Disagree; 3. Neither disagree nor agree; 4. Agree; 5. Strongly agree, a high score indicated a high level in the personality trait.

Procedure:

Participants were contacted individually at their place of living and at their place of workout i.e. gym. Respondents were clearly informed about the purpose of the study. After establishing the rapport with the participants, he/she was asked to understand the general instructions, however the instructions for specific tests were provided separately. When the subjects were comfortable with instructions and ready for testing, questionnaires were given. She/he was asked to answer each and every item of all the administered questionnaires and was ensured that the responses given by him/her would be kept confidential.

RESULT AND DISCUSSION:

In order to the test hypotheses framed with reference to objective of the study data were analyzed using F-test. When the statistical analysis regarding the effect on conscientiousness among call-center employees was carried out interesting results were obtained. These result are presented in table no.1, 2 and 3

Table 1, **The Mean for independent variables on conscientiousness according to 2x2 factorial design.**

Gender / **Marital status**	**Male =A_1 n=100**	**Female =A_2 n=100**	**Total N=200**
Married= B_1	M=29.76 n=50	M=27.42 n=50	M=28.59 n=100
unmarried= B_2	M=30.18 n=50	M=28.94 n=50	M=29.56 n=100
Total	M=29.97 n=100	M=28.18 n=100	M=29.08 N=200

Table 2, The Mean and Mean Deference for independent variables on conscientiousness according to 2x2 factorial design.

	Variables	N	Mean	Deference
A1	Male	100	29.97	1.79
A2	Female	100	28.18	
B1	Married	100	28.59	0.97
B2	Unmarried	100	29.56	

We have seen the table no.2 the Mean and Mean Deference or independent variables on conscientiousness that the averages mean score for male employees were very high than female employees. The highest mean score 29.97 was high conscientiousness of male employees and lowest mean score 28.18 was low conscientiousness of female employees. So we have seen the all mean result and conclude that male and female employees differ on conscientiousness and the deference was 1.97 between them. In marital status variable, unmarried (M=29.56) employees were high conscientious than married (M=28.59) employees.

Table 3, F calculation for conscientiousness (2x2 factorial designed)

Source of Variation	Sum of Squre (S.S.)	df	Mean of Squre (M.S.)	F-Values	Sig.
Ass (male/female)	60.205	01	60.205	8.07	0.01**
Bss (married/unmarried)	47.050	01	47.050	2.37	NS
ABss	222.375	01	222.375	11.21	0.01**
Wss	3885.245	196	19.84	-	-
Total	4317.875	199	-	-	-

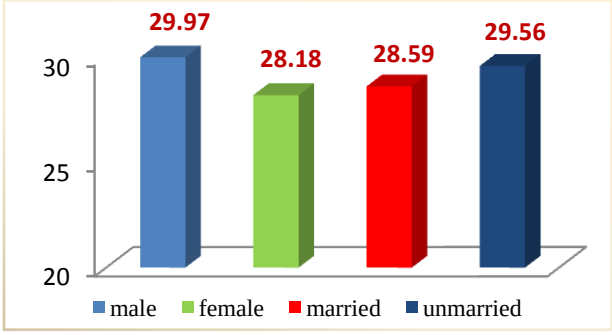
Significance levels 0.05* = 3.89 and 0.01** = 6.76

We have seen the table no.3 that F-value of gender variable was 8.07, which was significance at **0.01** levels. Result reveled that there is a significant difference between male and female call-center employees. According to table no.1 male were high conscientious than female. **Patricia J. Moran Alan J. Christensen, William J. Lawton *University of Iowa* (1997)** revealed a significant interaction between social support and conscientiousness. Generally we all feel that in comparison to female male were get full social support. Results of a few studies are in support of current result as they revealed gender differences in conscientiousness.

Further analysis was carried out to know if married and unmarried employees differ on conscientiousness, F-value of marital status was 2.37 which were not significant at both level. It portrayed that married and unmarried employee both are same level of conscientiousness, didn't any significant difference between them.

Similar analysis was carried out for interaction of gender and marital status among call-center employees. F-values (11.21) have been obtained. It portrayed that there are significant interaction between variable of gender and marital status.

Chart: 1, Conscientiousness



CONCLUSION:

Thus, results of the present study portrayed that male employees were highly conscientious than female employees .It was also observed that marital status doesn't make any difference in conscientiousness. At last one question raise in my mind why gender difference is seen everywhere!

REFERENCES:

1. Bakker, A. B., van Der Zee, K. I., Lewig, K. A., & Dollard, M. F. 2006. The relationship between the big five personality factors and burnout: A study among volunteer councillors. The Journal of Social Psychology, 146: 31-50.
2. Barrick, M. R., & Mount, M. K. 1993. Autonomy as a moderator of the relationship between the Big Five personality dimensions and job performance. Journal of Applied Psychology, 78: 111-118.
3. Costa, P. T. Jr., & McCrae, R. R. (1989). NEO PI/FFI manual supplement. Odessa, FL: Psychological Assessment Resources.
4. Costa, P. T. Jr., & McCrae, R. R. (1992). Normal personality assessment in clinical practice: The NEO Personality Inventory.Psychological Assessment, 4, 5_13.
5. John, O. P., & Srivastava, S. 1999. The Big-Five taxonomy: History, measurement and theoretical perspectives. In L. Pervin & O. P. John (Eds.), Handbook of Personality: Theory and Research, (2nd ed.). 102-138. New York: Guilford.
6. Jonker, B. (2004). A Master's mini-dissertation on *burnout, job stress and personality traits in South African Police Service*: North West University, South Africa
7. http://works.bepress.com/alan_christensen/6/
8. http://link.springer.com/article/10.1007/BF028950

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00222V2I12014
http://www.ijip.in | Oct to Dec 2014

Study of Personality Traits of Tobacco-Users and Non-Users among Students

Dr. Ruturaj H. Jaiswal*

ABSTRACT:

Tobacco use is a multi- dimensional and a worldwide problem with an alarming increase in its incidences. Adolescence continuing use of tobacco is major public health problem in India. The present study was attempted to study the personality traits of tobacco users (TU) than tobacco non-users (TNU) students. The purposive sampling method was adopted to select the sample. The sample consisted of 100 subject with tobacco users (n=50) and non-users (n=50) were selected from different schools and colleges of Jamnagar city of Gujarat state. The tools used were Eysenck's Personality Inventory, gujarati version. Student-T test was used to analyses the data. The present study revealed that there is significant difference between student tobacco users and non-users on Neuroticism and Extraversion dimensions of personality. Student tobacco users score higher on both dimensions of personality than non-users. Conclusion: when tobacco prevention and intervention program are developed, these personality traits should be consider in addition to physiological aspects.

Keywords: *Personality, tobacco user, tobacco non-user*

INDIAN PSYCHOLOGY

INTRODUCTION

Tobacco is the most widely distributed and commonly used drug in the world, today. Tobacco use usually begins in adolescence, the time for discovery, challenge and experimentation. Based on the current trends, the WHO, predicts that by the year 2020, tobacco use will cause more than 10 million deaths per year (Warren et al, 2008).The risk of tobacco use are highest among those who start early and continue its use for a long period (Sinha, 2002).

As per Bate et al (2009), and Tesering et al (2010), each day in India, an estimated 5500 youth initiate tobacco use, contributing to predictions that by 2020, tobacco will account for 13% of all death in India. According to Global Youth Tobacco Survey (GYTS 2003), in Gujarat, tobacco usage is 29.3% among the boys and 4.3% among the girls of class 8 to 10.Two in every five daily tobacco users age 20-34 had started using tobacco daily before attaining the age of 18. (GATS-INDIA, 2009-2010).The number of adolescence continuing to use tobacco in any form remains the major public health problem in India.

*Clinical Psychologist, Hospital for Mental Health, Jamnagar, Gujarat

© 2014 R Jaiswal; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

Almost half of the students, both from schools and colleges were aware about the close association between tobacco/ gutkha and oral cancer (Parwal et al), and other health consequences of tobacco consumption, many young people start tobacco use during adolescence. In India, government and many NGOs run program for tobacco control and prevention, despite of ban on smoking, it has shown limited impact on smoking habit (Bhatia et al, 2009).

The failure of anti-tobacco use program may have been inevitable by not considering intrinsic psychological factors due to the prevailing assumption that young adults are driven solely by extrinsic and social factors when choosing to smoke or mot to smoke (Lynch, 1995; O'Toole et al, 2001). Tobacco use is an interactional phenomenon, where in, apart from the tobacco or a toxic agent and social environment, the personality characteristics of the individual also play an important role.

There are several studies in the literature associating tobacco use and personality characteristics. Many studies found that smokers are more extroverts (Cattell et al, 1967; Smith, 1969; Coan, 1973, Lipkus et al,1994;).Smokers are more aroused and potentially irritated or angered more easily than non-smokers(David,1988). According to Coan(1973), smokers tend to be more extroverted, more distress prone, more liberal, more open to experience and more inclined to favor spontaneity than non-smokers. Berger (1971) reported that smokers revealed a preference for excitement and admitted to behavior conflicting with authority or social more. Cherry and Kiernan (1976) found that extroverts were more likely to smoke than introverts. In the recent past, Kara & Jennifer (2008) reported that smokers would have higher score on extraversion than non-smokers. On the other hand few researchers not found difference on extraversion (McCrae et al, 1987; Sijuwola, 1989).

One study on same issue indicate that person who had lifetime diagnosis of tobacco dependence according to ICD-10, DSM-4 or FTQ criteria were scored significantly higher on neuroticism scale of Eysenck than non- dependent ever smokers (Kawakami et al, 2000).There are some studies, which showed strong relation between smokeless tobacco use (Charles et al, 1999; John et al, 1993), smoker (Kara & Jenifer, 2008) and extroversion and neuroticism. Cherry and Kiernan (1976) and McCrae et al (1987) recorded that high N score were found to be more likely to smoke than those with low score. Recent past, Joseph (2010) and Julie(2008) reported relationship between smoking and depression. On the other side, few researchers reported that N was not related to smoking (Parkes, 1984). Sijuwola (1989) concluded that no significance difference between tobacco users and non-users on N scale of the Eysenck Personality questionnaire. Most of researchers suggest that further studies are required, comprising different populations from different geographic, social and cultural contexts, in order to provide more conclusive data.

As per above observation, purpose of the present study was to investigate the personality traits of students who consume tobacco, which may contribute to control and preventive and treatment

activities in the future. And it would be a kind of contribution towards the development and progress of our society and nation.

OBJECTIVE

Objective of the present study is to find whether there is a significant difference in personality traits of students who are tobacco user and non-user.

HYPOTHESIS

For the above mentioned objective, following null hypotheses was formulated:

1. There will be no significance difference between student tobacco users and non-users in relation to their personality traits.

METHOD

Sample:

The present study was conducted on a sample of 100 students among which 50 are tobacco users and 50 are non-users, with the age range of 16 to 20 years. The purposive sampling method was used to select sample from Jamnagar District of Gujarat.

Tools:

Gujarati adaptation of Eysenck's Maudsley Personality Inventory was used for the present study. It was developed by Dr. D. J. Bhatt. This test can be used as a group and an individual test, for persons of ages 15 to 16 and above. It consist 48 items, which measures two personality dimension ,namely, Neuroticism - Stability (N) and Introversion - Extraversion (E).24 items or question for each dimension. The test gives a maximum score of 48 on N, and also 48 on E dimension of personality. High score indicate higher level of neuroticism and extraversion. The reliability coefficient by test-retest method for N and E scale is 0.76 and 0.74 respectively, and by split-half method 0.85 and 0.96 respectively. Bhatt (1999) reported high validity of gujarati version of MPI.

Procedure:

Initially, the participants were contacted and their willingness to participate in the study was sought. Preliminary information like age, gender, education, tobacco use or not etc. were collected. Then, Maudsley personality inventory was administered on them. On average respondents required 15 to 20 minutes to complete the inventory. After the collection of data, the data obtained were scored individually for each subject. In order to fulfill the objective of the study and to prove the hypothesis formulated, the scores obtained were then analyzed by using mean, standard deviation and t-test.

RESULT AND DISCUSSION

Table: 1 Mean, Standard Deviation and T-ratio of MPI scores of
50 Tobacco users (TU) and 50 Non-users (TNU) students

MPI traits	Group	Mean	S.D.	T-value	Level of Significance
Neuroticism	TU(50) TNU(50)	29.82 17.88	8.95 8.64	+ 6.78**	0.01
Extraversion	TU(50) TNU(50)	30.1 28.0	3.89 5.35	2.24*	0.05

*P<0.05; **P<0.01

The above table shows there is a significant difference between the mean scores of tobacco user and non-user students on neuroticism and extraversion dimension of personality. Tobacco user students have higher score on Neuroticism as compared to non-users. Eysenck (1975), describes high N scorer as being an anxious, worrying individual, moody and frequently depressed, he is overly emotional, reacting too strongly to all sorts of stimuli, and find it difficult to get back on an even keel after each emotionally arousing experience. His strong emotional reactions interfere with his proper adjustment, making him react in irrational, sometimes rigid ways. (Hall et al, 2007, p.371).The possible reason of this finding may be those who score high on N may smoke to reduce tension and anxiety (Eysenck, 1980).

The findings of present study support the few earlier studies which showed that tobacco users scored higher on neuroticism in comparison to non-users (Kara & Jenifer, 2008; Kawakami et al, 2000; Charles et al,1995; John et al;1993; McCrae et al, 1987; Cherry & Kiernan,1976).Joseph et al (2010) also found cause and effect relationship between smoking and depression. Julie et al (2008), also suggest that smoking increase the risk of major depressive disorder. And contradict previous studies of Parkes (1984) and Sijuwola (1989) who reported no significance difference on N scale.

Table-1 also shows that Tobacco user students have higher score on Extraversion as compared to non-users. According to Eysenck, extravert is sociable, like parties, has many friends, needs to have people to talk to, and does not like reading or studying by himself; they craves excitement. Takes chances, often stick his neck out, acts on the spur of the moment, and is generally an impulsive individual; and generally likes change; he is care free, easy-going, optimistic, and likes to laugh and be merry; prefers to keep moving and doing things, tends to be aggressive and lose his temper easily; altogether his feelings are not kept under tight control, and he is not always a reliable person (Hall et al,2007). It may be due to person scoring high on Extraversion may smoke because they seek stimulation (Eysenck, 1980).

The findings of present study support the previous findings which found tobacco users are more extroverts (Cattell et al,1967; Smith,1969; Coan 1973, Cherry & Kiernan,1976; Lipkus et al, 1994; Kara & Jennifer,2008), more aroused and angered (David,1988), preference for excitement(Berger,1971).And contradict previous studies of McCrae et al (1987), Sijuwola (1989) which concluded that no difference between tobacco users and non-users on extraversion.

In summary, the present researcher feels that the above mention personality traits of young generation should be given emphasis for anti tobacco prevention and intervention program in

addition to physiological aspects. Adolescence and students should be the target group for the anti tobacco awareness program because they are the future adult who will develop and represent our nation.

REFERENCES

1. Bate, S.L., Stigler, M.H., Thompson, M.S., Arrora, M., Perry, C.L., Reddy, K.S., et al (2009). Psychosocial mediators of a school based tobacco prevention program in India: Result from the first year of project MYTRI. Preventive Science.10:116-28
2. Bhatia, V., Puri, S., Kaur, A., Vijayawwt, M., (2009). Impact of ban of smo0king in first smoke free city of Chandigarh in India. Indian Journal of Cancer.2010:47:109-210.
3. Bhatt, D.J.(1999).Manual of the Maudsley Personality Inventory.Viral prakashan, Amadavad.
4. Berger, Emanuel M.(1971). MMPI item differences between smoker and nonsmoker college freshman males. Journal of counsulting and clinical psychology, Jun, 36(3):446.
5. Cattle, R.B., Krug, Samuel.(1967). Personality factor profile peculiar to the student smoker. Journal of counseling psychology. 14(2):116-121.
6. Charles, D.S., John, P.F., G Ken Goodrick and Eric C Rehesier (1999).Personality characteristics of users of smokeless tobacco compared with cigarette smokers and non-users of tobacco products. Personality and Individual Differences,19(4): 439-448.
7. Cherry, N., & Kiernan, K.(1976). Personality scores and smoking behavior. A longitudinal study. British J Preventive Social Medicine.Jun; 30(2):123-31.
8. Coan, Richard W. (1973). Personality variables associated with cigarette smoking. Journal of Personality and social psychology. 26(1):86-104.
9. David, G.G. (1988). EEG and personality difference between smokers and non-smokers. Personality and Individual differences. 9(3): 659-665.
10. Eysenck, H. J. (1980). The causes and effects of smoking. Beverly Hills, CA7 Sage.
11. Hall, G.S., Lindzey, G., Campbell, J.B. (2007). Theories of Personality (4^{th} edt.) p.370-71, John Wiley publication: Noida.
12. John, D.F., Andrew, S.J., William, G.S. Jr.,G Harely Hartung, Tinker D Murry, Antonio M Gotto Jr.(1993). Psychological profile of college students who use smokeless tobacco. Addictive Behaviors. 18(2): 107- 116.
13. Joseph M. Boden, David M. Fergusson, and L. John Horwood(2010) Cigarette smoking and depression: tests of causal linkages using a longitudinal birth cohort. The British Journal of Psychiatry (2010) 196: 440-446.
14. Julie A. Pasco, Lana J. Williams, Felice N. Jacka, Felicity Ng, Margaret J. Henry, Geoffrey C. Nicholson, and Mark A. Kotowicz, Michael Berk,*(2008)* Tobacco smoking as a risk factor for major depressive disorder: population-based study The British Journal of Psychiatry*;193:322-326.*
15. Kara Hames; Jennifer SP. (2008) Personality and social differences of cigarette smoking among college students.USC Upstate Undergraduate Research Journal(Spring); volume 1: 7-12.

16. Kawakami, N., Takai, A.,Takatsuka, Shimizu H.(2000).Eysenck's personality and tobacco/nicotine dependence in male ever smoker in Japan. Addictive Behaviors. 25(4): 858-91.
17. Lipkus, I.M., Barefoot, John, C., Williams, Redford, B., Siegler, Hene, C. (1994). Personality measure as predictors of smoking initiation and cessation in the UNC alumni Heart Study. Health Psychology.13 (2):149-155.
18. Lynch, P. (1995). Adolescent smoking: An alternative perspective using personal construct theory. Health Education Research, 10, 95-106.
19. McCrae, R.R., Costa, P.T. Jr., Bosse, R.(1987). Anxiety, extraversion and smoking. British J Social Clin. Psychology. Sep; 17(3): 269-73.
20. O'Tool, T.P., Torabi, M.R. (2001). A comparison of personality types considering tobacco use. American Journal of Health Studies. Available on :http://findarticles.com /p/articles /mi_m0CTG/is_1_17/ai_ai83662682/
21. Parkes, K.R.(1984). Smoking and the Eysenck personality dimensions: an interactive model. Psychological Medicine.Nov.;14(4): 825-34.
22. Parwal, A.B., Mukherjee, short article. Guthka and Tobacco consumption and awareness of their health hazards among school and college students in Gujarat.
23. Sijuwola, O.A.(1989). Dimension of personality and smoking behavior. African J Med Sci.Jun 18(2): 105-8.
24. Sinha, D.N. Report on the result of the Global youth tobacco survey in U.P., India 2002. (http://www.searo.who.int/LinkFiles/GYTSR Uttarpradesh_2002.pdf.)
25. Smith, Gene, M. (1969).Relationship between personality and smoking behavior in preadult subject. Journal of counseling and Clinical Psychology. 33(6):710-715.
26. Tesering, D., Pal, R., Dasgupta, A. (2010). Licit and illicit substance use by adolescent student in eastern India: Prevalence and associated risk factors. Journal of Neuroscience Rural practice. 1: 76-81.
27. Warren, C.W., Jones, N.R., Peruga, A., Chauvin, J., Baptiste, J., Costa de Silva, et al.(2008). Global youth tobacco surveillance,2000-2007.MMWR surveillance summary 2008; 57:1-28

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00223V2I12014
http://www.ijip.in | Oct to Dec 2014

Me-Generation: The New Culture of Consumerism

Sisodia Devendra Singh*

ABSTRACT:

In the present era of free trade subject of consumerism is of prime concern. In the materialistic world consumerism plays vital role, increase in purchasing power with wide range of consumer items relating to new satisfaction of materialistic needs has led to a vast number of people availing of these opportunities in changing their whole lifestyle. A study was undertaken on a sample to see the change in value norms. The emerging value system would be of immediate need satisfaction "success" the key word of the "me generation", the term popularly used for members of the new culture of consumerism.

Keywords: *Me- Generation, Consumerism, Materialistic World, Consumption, Success, Sociogenic Traits, Behavioural Mode, Value System, Free Trade.*

INTRODUCTION

The present era is one of free trade and economic development. Most countries are now liberalizing and throwing open their economy, in order to raise the level of economic functioning. The main aim in the majority of cases is to raise the standard of living, raise people's purchasing power especially of those below the poverty line: raise the level of finances available with institutions for welfare and defence purposes. The fact remains that industrial growth is found necessary at this stage, for several nations, including India. India too is gearing up for all this, making efforts to join the global economic community and trying to reach a level of economic functioning equal to any global economy. Thus India too, faces a growing economy, with aims being consequently achieved.

Industrial growth, especially in India, is based upon increasing industrial production through conducive conditions of market and government regulations.

This in turn provides more employment and purchasing power which in turn provides more purchasing and hence, finally more demand for product and more production-industrial growth. This is a basic tenant of economic theory. This raises the problem that there will be an increase in the use of consumer goods in India which have traditionally not been available and in use.

*Head, Department of Psychology, BN Girls College, MLS University, Udaipur

© 2014 S Singh; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

The Indian culture is a phenomenon having wide variety and diversity. But the essential ingredients have been the same that is the unifying factor integrating the vast number of geographic and political units. The value system, orientation and different consumption strata have been essentially the same, so have the social institutions of caste, occupation, cognition, et al., including standard of living strata, all this is, in effect, brought about by the socialization, which moulds individual behaviour, into conformity with social norms, values and objectives or motives. Individually, thus it develops a behavioural mode determing a set pattern of behavior in terms of values, attitudes, cognitions, perceptions, alternative modes of action, aspiration and achievement levels. Consequently a typical set of need satisfaction patterns and a self identity of the individual are developed. It goes with the self identity that several covert factors determine the identity and thus selected behavioural mode of the individual. This is constantly referred by the individual in his effort to confirm his actual reality, self image and real image.

This external confirmation of the behavioural mode is usually in terms of items of consumption. This reflects both his need satisfaction pattern and his achievement level. These are the crux of what is happening to the behavioural mode. One indicator of the casual psychological factors for these behaviours is the cognitive organization of individuals termed values.

'Consumerism' is the term given to the new cultural phenomenon of spending a greater part of the income on consumption of items than on saving or investing, unlike Keynesian assumptions, instead of an increase in consumption and expenditure. This has been confirmed in the NCAER household consumption data survey (2012).

This is intrinsically linked to individual values; need structure and hence actual consumption patterns. These three variables have been chosen as a basis of measuring behavioural modes.

The emerging trends as sociogenic traits which are a resultant of social processes. Further if these sociogenic traits are predominant and enduring as inferred by cross sectional data then these may be taken to reflect cultural trends, related to achievement orientation, values of success, need gratification and so on.

METHOD AND PROCEDURE

The research problem is thus to study the trends in behavioural modes in a cross sectional sample and to find out if there emerges any cultural factors showing a change in terms of consumerism.

The objective is thus to study the variables grouped under the behavioural mode, and to find out if any inferences can be made from this data set and analysis with regard to sociogenic traits and cultural identity factor. The design was therefore constructed to reflect a change in cultural identity where a cross-sectional sample is more feasible here than a longitudinal study. Thus one independent variable is age other is 'n' achievement as a relevant and rather influential factor affecting consumerism. The dependent variable was the behavioural mode. This is defined here operationally as "the total score of the values need structure and consumption pattern".

Sample was chosen with age group less than 21 years to represent new generation which is culturally different from the other age group of above 45 years with more traditional values.

Achievement criterion was above 70% academic achievements on an average and below 50% same for high and low achievement respectively. It was hypothesized that there would be no significant differences between high and low "n" achievement with respect to behavioral mode. Further there would be no significant differences between older and younger groups with regard to behavioural mode. The methodology comprised development of an S. D. T. based tool for discriminating between the three criterions of usefulness, need structure frequency of use consumption pattern and value or desirability consumption values on a list of items. These items were chosen on the basis of economic data regarding availability and consumption expenditure volumes and trends with regard to all classes of consumption items like food, clothing, durable goods, etc (sources C. S. O., CMIE, publications, NCAER National household surveys, Indian economic information Year books, et al. India,2013).

RESULTS

	C.V.	**C.P.**	**N.S.**	**B.M.**		**C.V.**	**C.P.**	**N.S.**	**B.M.**
High	73	69	71	213		68	53	54	175
Low	56	72	71	199		58	56	56	169

Mature Adults (More Than 45 Years) **Age** Youth (Less Than 21 Years)

Where:

C.V. = Consumption Values C.P. = Consumption Pattern

N.S. = Need Structure B.M. = Behavioural Mode

DISCUSSION AND INTERPRETATION:

From the above table several trends emerge. The foremost was that, the mature adults group scores of behavioural mode are generally higher than that of youth group scores, irrespective mode was generally higher than youth group scores, irrespective of the influence of independent variable 'n' achievement.

A possible explanation of mature age group in both blocks of "n" achievement achieving higher behavioural mode scores than youth group of both blocks of "n" achievement may be that they may be more used to a consumption pattern which has grown over the years and their established professional or public life requires use of such items. One factor may be that values regarding the respect and priority of consumption given to age in Indian society are still alive.

Further, an analysis of behavioural mode constituents show that mature adults group score nearly the same in consumption values in their respective "n" achievement blocks, while their score in consumption pattern is far higher than youth group scores, thus inflating the behavioural mode scores comparatively. This may be explained by the fact that in a single income group, the mature adults group members of a family are the priority and high frequency users of most

consumer items and consider the durables and convenience items as essential while youth group respondents in the same family and income groups do not yet have the same necessity and frequency of use of these said items. Thus their score may be lower than the mature adults group in items of need structure and consumption pattern but in term of value their scores are higher.

As far as "n" achievement goes there is a confirmation of generally observed trend that high achievement Need Level goes with higher achievement in consumption pattern, a higher level of need and values indicating a higher level of consumption. In terms of consumption values there is a large difference in the mature adults group showing a wide gulf between high and low "n" achievement groups in this age group.

This may be the real indicator of conflicting cultural values of traditionally low materialistic need satisfaction versus the high materialistic need satisfaction pattern. Further one sees the gap narrowing for youth group. This trend shows that whatever the consumption pattern and need structure, the consumption value gap is less in mature adults group for low and high "n" in sample. This Trend shows the spread of materialistic values in the younger age group.

Thus there is definite shift in values from conservative to what can only be termed as materialistic. What emerges from these behavioural mode scores is that the value system is showing changes in overall and so is the need structure, as seen from the aggregate scores.

The last discussed trend of difference in the gap of high and low "n" achievement groups in both age groups, seems to indicate that apart from consumption values, the value system seems to be changing. The specific culture wide changes that seem apparent are that "n" achievement levels are increasing especially with respect to consumption items. This is possibly a matter for further exploration with greater operational controls and more in depth definition.

This emerging trend seems to confirm the work of Tom Wolf (1976) in calling the newly emerging consumerist or materialistic generation as the "me generation" which has high consumption values and also aims at achieving those consumption values and need structure scores irrespective of present consumption pattern levels.

What is definitely concluded is that there is an increasing aspiration level for higher standard of living, inspite of insignificant relationship in most of the cell blocks in the present study, which may be casual or concomitant variables of higher economic growth level of functioning according to Galbraith in the affluent society.

REFERENCES:

1. Anderson Bany (1975) “Cognitive Psychology”, Academic Press, London.
2. Gupta R.D (1999) “Keynes; Post Keynesian Economics”, Gupta Prakashan, Agra.
3. Katona George (2004) “Consumer Decisions Processes”, Prentice Hall, London.
4. Kerlinger (1983) “Foundation of Behavioural Research” Surjeet publication, Delhi.
5. Loudon and Della Bitta, (2009) .Consumer Behavior, Concepts and Applications ISE, McGraw Hill, New York.
6. Margin, (2012) NCAER Publications.
7. Newcomb Turner (2009) Converse “Social Psychology”, Routledge and Kegan Paul Ltd., Britain.
8. Samuelson P. E. (2013) “Economics” McGraw Hill, New York.
9. Wolf Tom (1976) “Self Identity Journal of Applied Psychological Research”.

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00224V2I12014
http://www.ijip.in | Oct to Dec 2014

A Comparative Study of Job Satisfaction in Government and Private Employees

Ajay Chauhan*, Dr. Pravin M. Solanki**

ABSTRACT:

The main objective of the present study is to examine the job satisfaction among government and private employees. A sample of 60 male and female employees was drawn randomly drawn from the population. The Generic Job Satisfaction Scale: Scale Development and Its Correlates, developed by Scott Macdonald and Peter Maclntyre (1997) was used for data collection. Data was collected by face to face interview method from the target population from different originations of Anand district. Mean, standard deviation and t-test were calculated for the analysis of data. Results indicate that there is no significant difference among government and private employees in job satisfaction.

Keywords: *Job Satisfaction, Private and Government Employees*

INTRODUCTION

Job satisfaction is a set of favorable or unfavorable feelings with which employees view their work. It is a worker's sense of achievement and success and is generally perceived to be directly linked to productivity as well as to personal wellbeing. The happier people are within their job, the more satisfied they are said to be. Job satisfaction implies doing a job one enjoys, doing it well, and being suitably rewarded for one's efforts. Job satisfaction can be influenced by a variety of factors, e.g., the quality of one's relationship with their supervisor, the quality of the physical environment in which they work, degree of fulfillment in their work, etc.. Job satisfaction further implies enthusiasm and happiness with one's work Job satisfaction; describes how satisfied an individual is with his or her job. Job satisfaction is not the same as motivation, although it is closely linked, but satisfaction includes the management style and culture, employee involvement, empowerment and autonomous work groups. Job satisfaction is a very important attribute which is frequently measured by organizations. The most common way of measurement is the use of rating scales where employees report their reactions to their jobs.

*MA, Clinical Psychology, Dept. of Psychology, Sardar Patel University, Vallabh Vidhyanagar, Guj. Ind
**PhD, Dept. of Psychology, M. K. Bhavnagar University, Bhavnagar, Guj. Ind

© 2014 A Chauhan, P Solanki; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

Questions related to rate of pay, work responsibilities, variety of tasks, promotional opportunities the work itself and co-workers. For the organization, job satisfaction of its workers means a work force that is motivated and committed to high quality performance. Increased productivity—the quantity and quality of output per hour worked—seems to be a byproduct of job satisfaction. Employee satisfaction surveys provide the information needed to improve levels of productivity, job satisfaction, and loyalty. Organizations can identify the root causes of job issues and create solutions for improvements with an accurate perspective of employee views discover what motivates people, what drives loyalty, and what genuinely makes and keeps your employees happy. Satisfaction levels increase when an employee knows that their issues are being addressed. There is a direct link between employee, job satisfaction and financial results. The more satisfied your employees are the more motivated and committed they will be towards the organization's success. In this Research paper we have tried to make a comparison of Job satisfaction between Private and Govt. sector and tried to find out the basic reasons of dissatisfaction in job.

REVIEW OF LITERATURE

The major objective of this Paper is to examine the nature and causes of job satisfaction. This was pursued through a literature review of the more popular theories and models related to job satisfaction. Included in the review are summaries of Maslow's and Alderfer's need hierarchy theories, achievement motivation theory, Herzberg's motivation-hygiene theory, expectancy theory, job characteristics theories, discrepancy theory, equity theory, and studies relating to the clustering of facet satisfactions. Job satisfaction is simply defined as doing a job one enjoys, doing it well, and being suitably rewarded for one's efforts. In other words, it is an effective response to a job that consequences from the comparison of perceived outcomes with those that are desired shortly, job satisfaction describes the feelings, attitudes or preferences of individuals regarding work (Chen, 2008). Furthermore, it is the degree to which employees enjoy their jobs (McCloskey and McCain, 1987). And also, it is possible to see a number of theories developed to understand its nature in literature. Vroom (1964), need/value fulfillment theory, states that there is negative relationship between individual needs and the extent to which the job supplies these needs.

OBJECTIVES

1. To study Job Satisfaction in Government and Private Employees.
2. To study Job Satisfaction in Government male and female employees.
3. To study Job Satisfaction in Private male and female employees.
4. To study Job Satisfaction in Government and Private male Employees.
5. To study Job Satisfaction in Government and Private female Employees.

HYPOTHESIS

1. There is no significant different between Government and Private Employees.
2. There is no significant different between Government male and female employees.
3. There is no significant different between Private male and female employees.
4. There is no significant different between Government and Private male Employees.
5. There is no significant different between Government and Private female Employees.

METHODOLOGY

Population

The population selected for this particular study is employees of government & private sector of different service sectors in Anand District (Gujarat State).

Sampling

The sampling population of this research includes 60 employees of government & private sector of different service sectors. This research followed the random sampling method representative population. The population belongs to an age group of 30-50.

Tools of data collection

The Generic Job Satisfaction Scale: Scale Development and Its Correlates, developed by Scott Macdonald and Peter Maclntyre (1997)

ANALYSIS AND RESULTS

Table no. 1, Job Satisfaction in Government and Private Employees.

Groups	N	Mean	SD	SEM	t	Level
Government	30	5.93	1.82	0.33	0.1840	NG
Private	30	6.03	2.36	0.43		0.01

The above table no. 1 shows the mean difference between two groups (government and private) in terms of job satisfaction. The mean for the government employees is 5.93 and SD 1.82, as well as the mean of private employees is 6.03 and SD 2.36. The obtained "t" is 0.1840, which is no significant at 0.01 levels. Hence it is concluded that there is no significant difference between government and private employees in terms of their job Satisfaction.

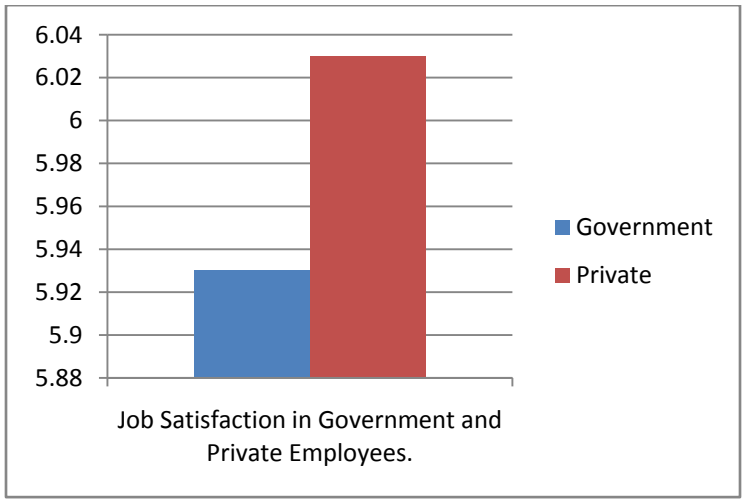


Table no. 2 Job Satisfaction in Government male and female Employees.

Groups	N	Mean	SD	SEM	t	Level
Male	15	5.80	1.66	0.43	0.3958	NS
Female	15	6.07	2.02	0.52		0.01

The above table no. 2 shows the mean difference between two groups (male and female) in terms of job satisfaction. The mean for the government male employees is 5.80 and SD 1.66, as well as the mean of female employees is 6.07 and SD 2.02. The obtained "t" is 0.3958, which is no significant at 0.01 levels. Hence it is concluded that there is no significant difference between government male and female employees in terms of their job Satisfaction.

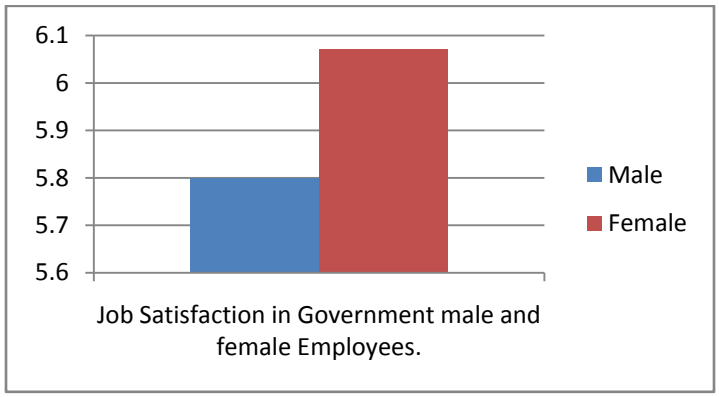


Table no.3 Job Satisfaction in Private male and female Employees.

Groups	N	Mean	SD	SEM	t	Level
Male	15	5.47	2.33	0.60	1.3351	NS
Female	15	6.60	2.32	0.60		0.01

The above table no. 3 shows the mean difference between two groups (male and female) in terms of job satisfaction. The mean for the private male employees is 5.47 and SD 2.33, as well as the mean of female employees is 6.60 and SD 2.32. The obtained "t" is 1.3351, which is no significant at 0.01 levels. Hence it is concluded that there is no significant difference between private male and female employees in terms of their job Satisfaction.

Table no.4, Job Satisfaction in Government and Private male Employees.

Groups	N	Mean	SD	SEM	t	Level
Government (M)	15	5.80	1.66	0.43	0.4521	NS 0.01
Private (M)	15	5.47	2.33	0.60		

The above table no. 4 shows the mean difference between two groups (male) in terms of job satisfaction. The mean for the government male employees is 5.80 and SD 1.66, as well as the mean of private male employees is 5.47 and SD 2.33. The obtained "t" is 0.4521, which is no significant at 0.01 levels. Hence it is concluded that there is no significant difference between government and private male's employees in terms of their job Satisfaction.

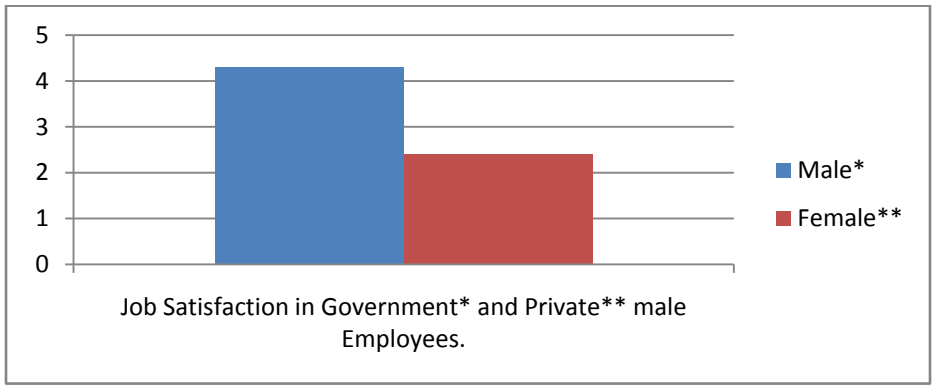
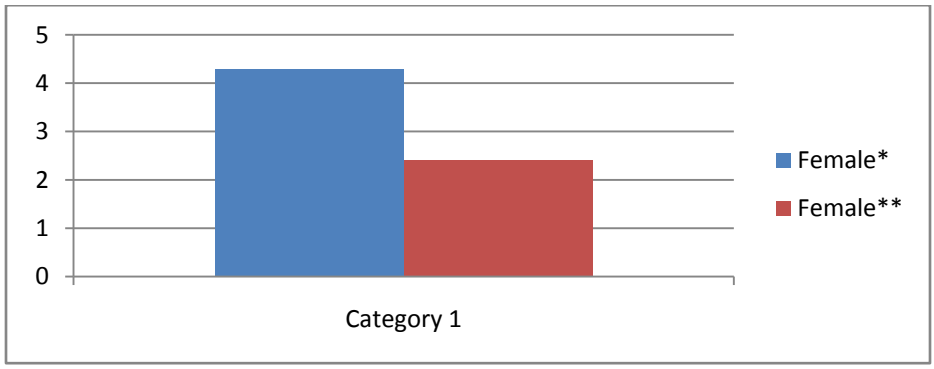


Table no. 5, Job Satisfaction in Government and Private female Employees.

Groups	N	Mean	SD	SEM	t	Level
Government (F)	15	6.07	2.02	0.52	0.6713	NS 0.01
Private (F)	15	6.60	2.32	0.60		

The above table no. 5 shows the mean difference between two groups (female) in terms of job satisfaction. The mean for the government female employees is 6.07 and SD 2.02, as well as the mean of private female employees is 6.60 and SD 2.32. The obtained "t" is 0.6713, which is no significant at 0.01 levels. Hence it is concluded that there is no significant difference between government and private female's employees in terms of their job Satisfaction.



CONCLUSION

1. No significant different between Government and Private Employees.
2. No significant different between Government male and female employees.
3. No significant different between Private male and female employees.
4. No significant different between Government and Private male Employees.
5. No significant different between Government and Private female Employees.

So, we accept the entire null hypothesis.

REFERENCE

1. Brief, cited in Weiss, H. M. Deconstructing job satisfaction: separating evaluations, beliefs and affective experiences. Human Resource Management Review,2002,12, 173-194
2. Fried Y, Ferris GR. The validity of the Job Characteristics Model: A review and meta-analysis. Personnel Psychology,1987,40,287-322
3. Rafaeli A, Sutton RI. The expression of emotion in organizational life. Research in Organizational Behavior,1989,11, 1–42
4. Abraham R. The impact of emotional dissonance on organizational commitment and intention to turnover. Journal of PsycholoGy,1999,133, 441–455
5. Morris JA, Feldman DC. Managing emotions in the workplace. Journal of Managerial Issues , 1997, 9, 257–274
6. Organ DW, Ryan KA Meta-analytic review of attitudinal and dispositional predictors of organizational citizenship behavior. Personnel Psychology,1995, 48, 775-802
7. Scott Macdonald and Peter Maclntyre (1997), The Generic Job Satisfaction Scale: Scale Development and Its Correlates, The Haworth Press Inc
8. Shobhna Gupta J, Hartesh Pannu K (2013), A Comparative Study of Job Satisfaction in Public and Private Sector, Indian Journal of Arts, V-1, N-1, 2013

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00225V2I12014
http://www.ijip.in | Oct to Dec 2014

A Comparative Study of Role Stress in Government and Private Hospital Doctors

Chirag Rathod*

ABSTRACT:

The main objective of the present study is to examine the role stress among government and private doctors. A sample of 60 male and female doctors was drawn randomly drawn from the population. The organizational role stress (ORS) developed by Pareek was used for data collection. Data was collected by face to face interview method from the target population from different hospitals of Anand district. Mean, standard deviation and t-test were calculated for the analysis of data. Results indicate that there is no significant difference among government and private doctors in role of stress.

Keywords: *Stress, Government and Private Hospitals Doctors*

INTRODUCTION

Stress is a feeling of tension or pressure that people experience when demands placed on them exceed the resources they have to meet these demands (Moore, 1995). There is a considerable debate among stress researchers about how to adequately define stress. According to Selye (1956), "Any external event or internal drive which threatens to upset the organism's equilibrium is stress." He has defined stress as the non-specific response of the body to any demand made upon it. Lazarus (1980) sees Stress as a result of a transaction between person and environment. Zimbardo (1988) defined stress as "the pattern of specific and non-specific responses an organism makes to stimulus events that disturbs its equilibrium and exceed its ability to cope. From the foregoing definitions it may be pointed out that the researchers explained the notion of stress from various perspectives: i) as an external force which is perceived as threatening; ii) as response to a situation demanding an individual to adapt to change, physically or psychologically; iii) as an interactional outcome of the external demand and internal resources; iv) as personal response to certain variations in the environment and v) a more comprehensive combination of all. Pestonjee (1992) has identified 3 important sectors of life in which stress originates (i) Organizational& Job sector (ii) Social sector and (iii) Intrapsychic sector. The focus of the present study is to understand stress in organizational/ job sector of life. Organizational/ Job stress has been defined in terms of a misfit between person"s skills & abilities and the -

*MA, Clinical Psychology, Dept. of Psychology, Sardar Patel University, Vallabh Vidhyanagar, Guj. Ind

© 2014 C Rathod; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

- demands of his/her job. The concept of Organizational/job stress falls under the umbrella of a broader concept i.e. Role Stress. Therefore, it becomes imperative to understand the concept of Organizational role, in order to understand the concept of stress in Organizational & job sector of life. According to Pareek (1993), Role denotes the set of functions one performs in response to the expectations of the significant others, and one's own expectations from that position or office. The organization and individual come together through role. Pareek (1980) pioneered work on role by identifying as many as 10 different types of organizational role stresses. Briefly these are: Inter Role Distance (IRD): Conflict between organizational and non-organizational roles. Role Stagnation (RS): "Feeling of being stuck in the same role." It results in the perception that there is no opportunity for learning & growth in the role. Role Expectation Conflict (REC): Conflicting demands made on the role by role senders. Role Erosion (RE): Feeling of "Responsibility without power." It is a feeling that some important functions a role occupant would like to perform has been given to some other roles. Role Overload (RO): A feeling that too much is expected from the role than what the occupant can cope with. Role Isolation (RI): Lack of linkages of one's role with other roles in the organization. Personal Inadequacy (PI): Lack of knowledge, skills or adequate preparation to be effective in a particular job. Self- Role Distance Conflicts of one "values and self-concepts with the requirements of the organizational role. Role Ambiguity Lack of clarity about expectations of others from the role, or lack of feedback on how performance is regarded by others. Resource Inadequacy Non-availability of resources needed for effective role performance.

OBJECTIVES

1. To study role stress in doctors working in Government and Private Hospitals.
2. To study role stress in male and female doctors working in Government Hospitals.
3. To study role stress in male and female doctors working in Private Hospitals.

HYPOTHESIS

1. There is no significant difference in Government and Private Hospitals doctors, about role stress.
2. There is no significant difference in male and female doctors of Government Hospitals.
3. There is no significant difference in male and female doctors of Private Hospitals.

VARIABLES

- **Independent Variables:**

Government and Private Hospitals doctors, Gender

- **Dependent Variable:**

Role Stress

TOOLS

The organizational role stress (ORS) scale, which was developed and standardized by Pareek in the year 1981 to measure the role stress, has been used in this study. The ORS scale is a 5 point scale (0-4) consisting of 50 statements which measures 10 role stressors (5 statements for each role stressor).

POPULATION

The population selected for this particular study is doctors of government & private hospitals of different service sectors in Anand District (Gujarat State).

SAMPLING

The sampling population of this research includes 60 doctors of government & private hospitals of different service sectors. This research followed the random sampling method representative population.

ANALYSIS FORMULA

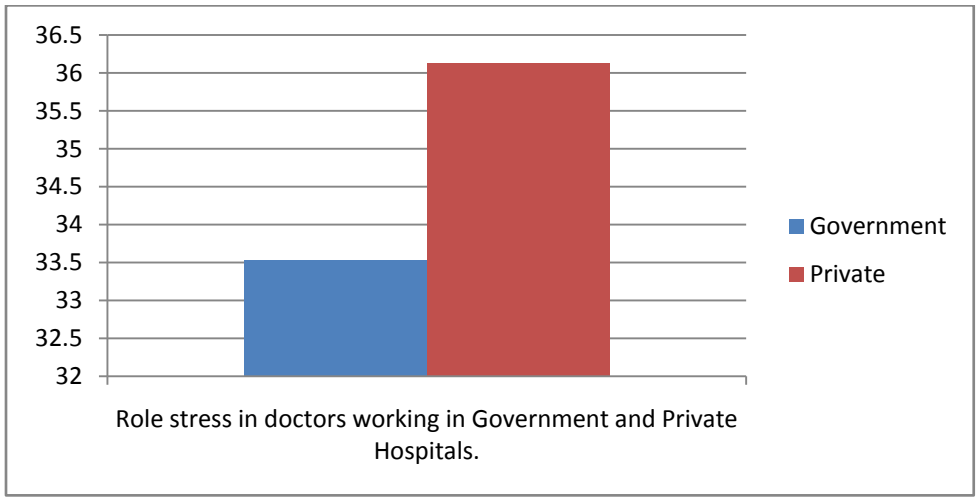
Here in this study the t‟-Test was conducted as a statistical technique to prove the aim.

RESULTS AND DISSECTION

1. **Table, Role stress in doctors working in Government and Private Hospitals.**

Group	N	Mean	SD	SEM	t	Level
Government	30	33.53	5.56	1.01	1.6497	NS
Private	30	36.13	6.61	1.21		0.01

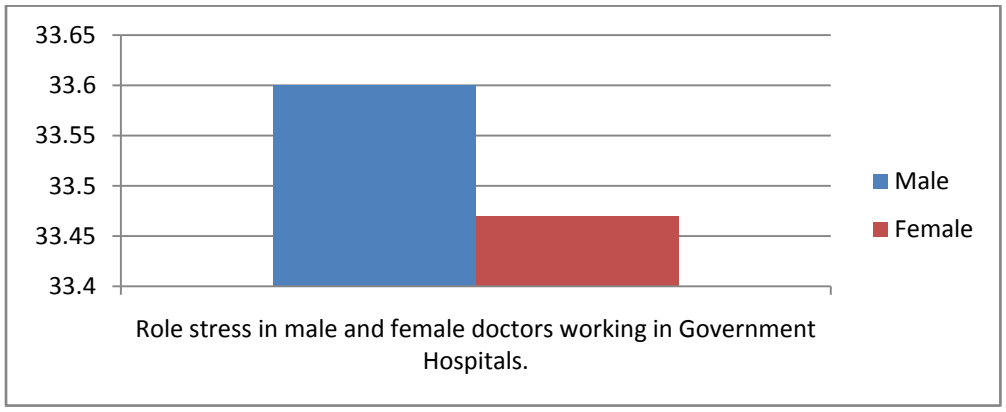
The above table no. 1 shows the mean difference between two groups (government and private hospitals) in terms of role stress. The mean for the government doctors is 33.53 and SD 5.56, as well as the mean of private doctors is 36.13 and SD 6.61. The obtained "t" is 1.6497, which is no significant at 0.01 levels. Hence it is concluded that there is no significant difference between government and private doctors in terms of their role stress.



2. Table, Role stress in male and female doctors working in Government Hospitals.

Group	N	Mean	SD	SEM	t	Level
Male doctors	15	33.60	6.13	1.58	0.0646	NS 0.01
Female doctors	15	33.47	5.14	1.33		

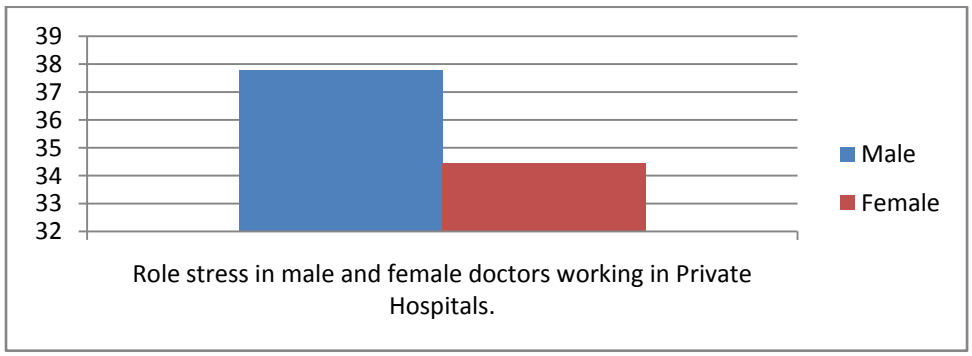
The above table no. 2 shows the mean difference between two groups (male and female) in terms of role stress. The mean for the government male doctors is 33.60 and SD 5.56, as well as the mean of female doctors is 33.47 and SD 5.14. The obtained "t" is 0.0646, which is no significant at 0.01 levels. Hence it is concluded that there is no significant difference between government male and female doctors in terms of their role stress.



3. Table, Role stress in male and female doctors working in Private Hospitals.

Group	N	Mean	SD	SEM	t	Level
Male doctors	15	37.80	3.51	0.91	1.4049	NS 0.01
Female doctors	15	34.47	8.49	2.19		

The above table no. 3 shows the mean difference between two groups (male and female) in terms of role stress. The mean for the private male doctors is 37.80 and SD 3.51, as well as the mean of female doctors is 34.47 and SD 8.49. The obtained "t" is 1.4049, which is no significant at 0.01 levels. Hence it is concluded that there is no significant difference between private male and female doctors in terms of their role stress.



CONCLUSION

1. No significant difference in Government and Private Hospitals doctors, about role stress, so we accept null hypothesis.
2. No significant difference in male and female doctors of Government Hospitals.
3. No significant difference in male and female doctors of Private Hospitals.

REFERENCE

1. Allibone, A. Oakes, D. & Shannon, H.S., 1981. The health and healthcare of doctors. Journal of the Royal College of General Practitioners, 31, pp. 728-731.
2. British Medical Association. Stress and the medical profession, London: BMA 2000.
3. Burke, RJ.&Richardson, AM., 1991. Sources of satisfaction and stress among Canadian physicians.Psychol Rep, 67, pp. 1335-1344.
4. Chambers, R., 1992. The health and lifestyle of general practitioners and teachers. Occupational Medicine, 42, pp. 69-78.
5. Cooper, C.L., Rout, U. &Faragher, B., 1989. Mental health, Job Satisfaction, and Job Stress among general practitioners. British Medical Journal, 298, pp. 366-370.
6. Gestal,JJ., 1987. Occupational hazards in hospitals: accidents, radiation, exposure to noxious chemicals, drug addiction and psychic problems and assault. BMJ, 44, pp. 510-520.
7. Gianakos, Irene. 2001. Gender Roles and Coping with work stress. Sex Roles. A Journal of Research (6),pp. 1-13.
8. Hirak, Dasgupta& Suresh, Kumar.,2009.Role Stress among Doctors Working in a Government Hospital n Shimla (India). European Journal of Social Sciences 9 (3),pp. 356-370.
9. l.-Aameri.&Al-Fawzan., 1998. Nurses‟ strategies for coping with job stress. Saudi Medical Journal, 19 (4), pp. 366-371.

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00226V2I12014
http://www.ijip.in | Oct to Dec 2014

Perceived Self- Esteem among Secondary and Higher Secondary School Teachers

Krutika Shah*, Dr. Sangeeta Pathak**

ABSTRACT:

The present research work aimed at finding out the difference between secondary and higher secondary school teachers on Self-esteem. For this purpose a total sample of 240 school teachers. Among them 120 secondary and 120 higher secondary school teachers. Data was collected by using Self-esteem scale developed by "Roseberry,(1965)". Results were analyzed by using F-Anova. Results revealed that there is no significant difference between secondary and higher secondary school teachers on Self-esteem.

Keywords: *Self-esteem, secondary and higher secondary school teachers.*

INTRODUCTION

Self - Esteem:

Self - esteem is a term used in psychology to reflect a person's overall emotional evaluation of his or her own worth. It is a judgment of oneself as well as an attitude toward the self. Self - esteem encompasses beliefs (for example, "I am competent ", "I am worthy") and emotions such as triumph, despair, paid and shame. Smith and Mackie define it by saying "The self - concept is what we think about the self; self - esteem is the positive or negative evaluation of the self as in how we feel about it". Self - esteem is also known as the evaluative dimension of the self that includes feeling of worthiness, Prides and discouragement. One's self - esteem is also closely associated with self - consciousness.

Self - esteem is a disposition that a person has which represents their judgments of their own worthiness. In the mid- 1960s, Morris Rosenberg and social - learning theorists defined self - esteem as a personal worth or worthiness. Nathaniel Branden in 1969 defined self - esteem as " the experience of being competent to cope with the basic challenges of life and being worthy of happiness". According to Branden, Self - esteem is the sum of self - confidence (a feeling of personal capacity) and self - respect (a feeling of personal worth). It exists as a consequence of the implicit judgment that every person has of their ability to face life's challenges to understand and solve problems and their right to achieve happiness and be giving respect.

*Research Scholar, Dept. of Psychology, Sardar Patel University, Vallbh Vidhyanagar, Gujarat, India
**Asso. Professor, Dept. of Psychology, Sardar Patel University, Vallbh Vidhyanagar, Gujarat, India

© 2014 K Shah, S Pathak; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

As a social psychological construct self- esteem is attractive because researchers have conceptualized it as an influential predictor of relevant out comes such as academic achievement (Marsh 1990) or exercise behaviour (Hagger et al.1998).In addition self - esteem has also been treated as an important outcome due to its close relation with psychological well - being (March 1989). Self - esteem can apply specifically to a particular dimension (for example, " I believe person and feel bad about myself in general"). Psychologists usually regard self - esteem as an enduring personality characteristic ("trait" self - esteem) though normal, short - term variations ("state" self - esteem) also exist synonyms or near - synonyms of self - esteem include: self - worth, self - regard, self - respect and self - integrity.

What is Self-Esteem?

Self-esteem generally refers to how we feel about or how we value ourselves. Self esteems a hypothetical construct that includes cognitive, behavioral, and affective components. Self-esteem represents an aspect of self-cognition that reflects one's perceptions about oneself. These perceptions are formed through the evaluation of one's own personal attributes and the internalization of the evaluations of others. Over the last decade, increased interest in self-esteem has been fueled by research linking high self-esteem and strong academic and social functioning in children. Conversely, low evaluations of global self-esteem appear to be associated with many personal and social concerns, such as school failure, depression, social anxiety, violence, substance abuse, and chronic welfare dependency. When parents and teachers of young children talk about the need for good self-esteem, they usually mean that children should have "good feelings" about themselves. With young children, self-esteem refers to the extent to which they expect to be accepted and valued by the adults and peers who are important to them. Self-esteem involves an individual's sense of self-worth (Beane, 1984, p.6)

PROBLEM STATEMENT:

"Perceived self esteem among secondary and higher secondary school teachers"

OBJECTIVE OF THE RESEARCH:-

1. To study self esteem of secondary and high secondary school teachers.
2. To study the gender difference in relation to the secondary and high secondary school teachers.
3. To study self esteem of those school teachers below 10 years.
4. To study self esteem of those school teachers above 10 years.

HYPOTHESIS OF THE RESEARCH:-

1. There will be no significant difference between secondary and higher secondary school teachers in relation to self esteem.
2. There will be no significant difference between male and female teachers in relation to self esteem.

3. There will be no significance difference between secondary and higher secondary school teachers 10years below experience on self esteem.
4. There will be no significance difference between secondary and higher secondary school teachers 10 years above experience on self esteem.

VARIABLES:

1. Independent variables:

Types of school: secondary and high secondary
Gender: Male/Female
Experience: 10 below and 10 above

2. Dependent variables:

Life satisfaction

RESEARCH DESIGN:

N=240, n=30

Variable	Secondary		Higher secondary		Total
Experience	Male	Female	Male	Female	
10 Below	30	30	30	30	120
10 Above	30	30	30	30	120
Total	60	60	60	60	240

SAMPLE:

In this research study of secondary and higher secondary school teacher shall be selected from anand city. These samples will random sampling method. A total of 240 teachers shall be selected out of which 120 would be secondary school teachers and Higher secondary school teachers out of which 60 would be male and 60 female from each of this 120 teachers 60 secondary and 60 higher secondary school teachers would take.

Tools:

For this study to collect required information the following told shall be used.

Personal Data sheet:-

A personal data sheet developed by investigator was used to collect information about types of school, sex, experience level, monthly income, marital status, types of family.

Self-esteem scale:-

It has been developed Roseberry (1965). The scale consists of 10 self-report items dealing with person's belief about himself. Each items is answered on a four point likert scale- from strongly agree (3) to strongly disagree (0) The scale was originally validated on a large sample of high school students. Test- Retest correlation are typically in the range of 0.82 to 0.88 & cronbanch's alpha for various samples are in the range of 0.77 to 0.88.

The scale is a ten item Likert scale with items answered on a four point scale - from strongly agree to strongly disagree. The original sample for which the scale was developed consisted of 5,024 High School Juniors and Seniors from 10 randomly selected schools in New York State.

Instructions: Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle **SA**. If you agree with the statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**.

Scoring: SA=3, A=2, D=1, SD=0. Items with an asterisk are reverse scored, that is, SA=0, A=1, D=2, SD=3. Sum the scores for the 10 items. The higher the score, the higher the self esteem.

The scale may be used without explicit permission. The author's family, however, would like to be kept informed of its use:

DISCUSSION OF RESULT:

TABLE- 1, **SHOWING RESULT OF ANOVA ON SELF ESTEEM**

Source of variance	**Sum of Square**	**df**	**Mean Square**	**F(sig.)**
Status	17.604	1	17.604	2.42 (NS)
Gender	0.504	1	0.504	0.07 (NS)
Experience	2.204	1	2.204	0.30 (NS)
Status * Gender	11.704	1	11.704	1.61 (NS)
Status* Experience	5.704	1	5.704	0.78 (NS)
Gender *Experience	45.937	1	45.937	6.32 (0.05)
Status*Gender*Experience	136.504	1	136.504	18.78 (0.01)
Error	1685.833	232	7.267	
Total	91265.00	240		

The results of ANOVA on perception reality score table 1 consulted and found that the F-ratio for status is 2.42 that is not significant. When df is1. Main effect (A) represents the factor of status. It was assumed that types of schools from two different status levels each differ from other significantly. As can be seen from the table no.4.9 secondary and higher secondary statuses are not differing from each other in relation to perception of school teachers.

TABLE-1.1, SHOWING MEAN DIFFERENCES IN SELF ESTEEM LEVEL WITH RESPECT TO STATUS

STATUS	N	MEAN	MEAN DIFFERENCE
Secondary	120	19.57	0.55
Higher secondary	120	19.02	
Total	240		

As shown in table 1.1, the mean value of secondary is 19.57and the mean value of higher secondary is19.02. There is a difference of very less i.e. 0.55 between the both which means they do not differ significantly much in their self esteem level with respect to their school status. The F value for the status 2.42. This mean there is no significant difference at both the level i.e. 0.01 and 0.05 level. Therefore, the third hypothesis there will be no significant difference between secondary and higher secondary school teachers in relation to self esteem is accepted. This suggests that the level of school status does not play a significant role in the level of self esteem of a person.

TABLE-1.2, SHOWING MEAN DIFFERENCES IN SELF ESTEEM LEVEL WITH RESPECT TO GENDER

GENDER	N	MEAN	MEAN DIFFERENCE
Male	120	19.34	0.09
Female	120	19.25	
Total	240		

As shown in table 1.2, the mean value of male is 19.34 and the mean value of female is 19.25. There is a difference of very less i.e. 0.09 between the both which means they do not differ significantly much in their self esteem level with respect to their gender. The F value for the status 0.07. This mean there is no significant difference at both the level i.e. 0.01 and 0.05 level. Therefore, the fourth hypothesis there will be no significant difference between male and female school teachers in relation to self esteem is accepted. This suggests that the level of gender does not play a significant role in the level of self esteem of a person.

TABLE-1.3, SHOWING MEAN DIFFERENCES IN SELF ESTEEM LEVEL WITH RESPECT TO EXPERIENCE

EXPERIENCE	N	MEAN	MEAN DIFFERENCE
10 Below	120	19.39	0.19
10 Above	120	19.20	
Total	240		

As shown in table 1.3, the mean value of teaching professionals with experience of 10 years below is 19.39 and the mean value of teaching professionals with experience of 10 years above is19.20. There is a difference of very less i.e. 0.19 between the both which means they do not differ significantly much in their self esteem level with respect to their teaching experiences. The F value for the experience is 0.30. This mean there is no significant difference at both the level i.e. 0.01 and 0.05 level. Therefore, the sixth hypothesis there will be no significance difference between secondary and higher secondary school teachers having experience more than 10 years and those having less then 10 years experience on self esteem is accepted. This suggests that the level of teaching experience does not play a significant role in the level of self esteem of a person.

RESEARCH FINDINGS:

STATUS:

There will be no significant difference between secondary and higher secondary school teachers in relation to self esteem is accepted. This suggests that the level of school status does not play a significant role in the level of self esteem of a person.

GENDER:

There will be no significant difference between male and female school teachers in relation to self esteem is accepted. This suggests that the level of gender does not play a significant role in the level of self esteem of a person.

EXPERIENCE:

There will be no significance difference between secondary and higher secondary school teachers having experience more than 10 years and those having less then 10 years experience on self esteem is accepted. This suggests that the level of teaching experience does not play a significant role in the level of self esteem of a person.

REFERENCE:

1. Beane, James A. (1984). Self Concept, Self-Esteem, and the Curriculum. New York: Teachers College Press

2. Beaumeister, Roy F. (Eds.). (1993). Self-Esteem, the pussle of Self-Regard. New York:Plenum Press.
3. Chang, E. C., & Sanna, L. J. (2001). Optimism, pessimism, and positive and negative affectivity in middle-aged adults: a test of a cognitive-affective model of psychological adjustment. Psychology and Aging, 16(3), 524-531.
4. Diener E & Denier M (1995) " Cross Cultural correlates of life satisfaction and self esteem" Journal of Personality and Social psychology 68, page No – 653-663.
5. DR. Hetal .T. Patel Impact of Self-Esteem on Personality and Adjustment Australian Journal of Educational & Developmental psychology.Vol3, 2003, pp-21-34. International Journal of Humanities and Social Science Vol.1 No.18.
6. Dr. Zeenat Ismail, Student Self-Esteem and Their Perception of Teacher Behaviour,'' A study of Class, International Journal of Business and social science'' Vol.2No.16; September2011. Journal of Personality and Social Psychology Copyright 2005 by the American Psychological Association 2005,Vol.89,No.4,623-642.
7. Judge, T.A., Erez, A., & Bono, J.E. (2002). Are measures of self-esteem, neuroticism, locus of control, and generalized self-efficacy indicators of a common core construct? *Journal of Personality and Social Psychology, 83,* 693–710.

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00227V2I12014
http://www.ijip.in | Oct to Dec 2014

A Study of Death Anxiety among Pre and Post Operated Cancer Patients

Rajendra Patel*, Dr. Pankaj Suvera**

ABSTRACT:

The present research work aimed at finding out the difference between pre and post cancer patients on Death anxiety. For this purpose a total sample of 200 cancer patients. Among them 100 pre and 100post operated cancer patients. Data was collected by using Death anxiety scale developed by Templer's [1970]. Results were analyzed by using F- ANOVA and t. Results revealed thatthere is no significant difference between pre and post operated cancer patient on death anxiety. There is wide difference between mean of male and female on their death anxiety.

Keywords: *Death anxiety, pre and post operated cancer patients.*

INTRODUCTION

A common denominator of cancer patients is their fear of death, regardless of personal characteristics, religious beliefs or cultural background. Although Muslims, Hindu, Krishnan etc. believe in life after death, fear of death exists in the culture even though it is a natural human experience. When patients are diagnosed with cancer, as opposed to other diseases, patients may have a greater fear of death. The cancer patient might be unique in the fact that the fear might come from the meaning that the patients attach to the word cancer and its association with death (Vilhuer, 2008).

Vilhuer also states that most patients have a fear of the unknown. Once the diagnosis of cancer has been made, patients start to experience feelings of fear, stress, depression, and worry of what the future holds for their lives. Researchers suggest that cancer and depression are related (Rodgers, Martin, Morse, Kendall, & Verrill, 2005). Death distress and anxiety level are associated with depression. This constant fear creates anxiety and depression which can affect day –to- day life and can become very distressing.

Pasquini and Biondi (2007) concluded that depression causes complications in the course of cancer and its treatment. It is not only the diagnosis of cancer that is related to the depression rate, but also the amount of pain the cancer patient feels, the socioeconomic issues, the religious beliefs or cultural attitudes toward the disease, and the ability to follow through on treatments -

*Research Scholar , Dept. of Psychology, Sardar Patel University, Vallbh Vidhyanagar, Gujarat, India
**Assi. Professor, Dept. of Psychology, Sardar Patel University, Vallbh Vidhyanagar, Gujarat, India

© 2014 R Patel, P Suvera; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

- that can all lead the patients to face this kind of stress (Vilhuer, 2008). Among people who have been diagnosed with cancer, patients with high levels of pain have much higher rates of depression than those with little or no pain (Tavoli, Montezeri, Rasook, Tavoli, &Mahdiyeh, 2008).

The majority of cancer patients have similar fears; fear of pain, death, loss of control and function. These fears may lead to suffering and depression; it is easy to understand the difficulty faced by cancer patients when they have to live their lives with the threat of their impending death always present (Sigal et al., 2008).death is a mysterious concept which also creates curiosity which defines the end of the life of the living and create no-occurrence, uncertainty, fear, despair and lack of hope, it is a constantly researched phenomenon. Death and the effort to solve its mystery has led to the effort of solving the secret of mortality and getting an absolute guarantee of existence. Attitudes, thoughts and behaviors towards death also show the life perspective of the individual and it show how that individual perceives life. Term of death anxiety refers not to the anxiety which is felt in the case of an urgent threat towards a person's life; it refers to the anxiety experienced in "daily life". Yalom (2000) says, "The fear of death exists always and everywhere and it is so great that, most of the life energy is spent in the moment of death (Yalom, 2000).Basically the thing that scares the individual is not the feeling that life will continue, but it is the feeling that it will end at some point. Deaths do not come to humankind in the normal flow of life. However, he/she feels it if he/she witnesses some events around him/her which could lead to death. Each individual's source of death anxiety may not bethe same. According to Imam, the death anxiety is stated not to be cultural, it is taught and it is not an anxiety coming "from the genes", death is stated to be always included in life and life is stated to be included in death.

RESEARCH PROBLEM:

"A Study of Death anxiety among Pre and Post operated Cancer Patients"

OBJECTIVES

1. To study of the death anxiety among pre and post operated cancer patients.
2. To study of the death anxiety among male and female cancer patients.
3. To study of the death anxiety among low, medium and high age of cancer patients.
4. To study of the death anxiety among blood and other cancer patients.
5. To study of the death anxiety among low, medium and high education qualification of the cancer patients.
6. To study of the death anxiety among urban and rural area of the cancer patients.
7. To study of the death anxiety among joint and nuclear family of the cancer patients.
8. To study of the death anxiety among low, medium, high income of the cancer patients.

HYPOTHESIS

1. There is no difference between death anxiety of pre and post operated cancer patients.
2. There is no difference between death anxiety of Male and female of the cancer patients.
3. There is no interaction effect of death anxiety on types of patients and sex of the cancer patients.
4. There is no difference between death anxiety of low and medium age of the cancer patients.
5. There is no difference between death anxiety of low and high age of the cancer patients.
6. There is no difference between death anxiety of medium and high age of the cancer patients.
7. There is no difference between death anxiety of blood and other cancer patients.
8. There is no difference between of death anxiety low and medium education of the cancer patients.
9. There is no difference between death anxiety of low and high education of the cancer patients.
10. There is no difference between death anxiety of medium and high education of the cancer patients.
11. There is no difference between death anxiety of urban and rural area of the cancer patients.
12. There is no difference between death anxiety of joint and nuclear family of the cancer patients.
13. There is no difference between death anxiety of low and medium income of the cancer patients.
14. There is no difference between death anxiety of low and high income of the cancer patients.
15. There is no difference between death anxiety of medium and high income of the cancer patients.

SELECTION OF SAMPLE:

Sampling is a powerful tool in social research. Sampling procedures make it possible to know how much confidence one can have that the information gathered is similar to the information that would have been gathered if one had studied everyone in the larger group.

In this research study of pre and post operated cancer patients shall be select from central Gujarat and these rural and urban area. This sample will select by random sampling method A total of 200 cancer patients selected out of which 100 pre operated and 100 post operated Cancer patients out of which 50 male and 50 female cancer patient's taken. Sample taken from hospital and NGO of Anand, Baroda, Ahemdabad, Dharmaj, Balasinor cites.

RESEARCH TOOLS:

For this study to collect the required information the following toots shall be used.

Personal data sheet:

A personal data sheet developed by investigator was used to collect information about types of patients, sex, age, types of cancer, education, area, types of family, income etc.

SCALES:

- **Death anxiety scale:**

Death anxiety scale developed by Templer's[1970] was used to measure death anxiety the scale contains 15 items with two, true and false response alterative the maximum possible score is zero high score indicates high level of death anxiety and low score indicated low level of death anxiety Templer has reported a test-retest reliability coefficient is 0.83 and internal consistency coefficient is 0.76 the author has report satisfactory validity of the questionnaire the Gujarat version used in the present study had correlation between 0.94 with the original English vision.

The scoring keys presentable below each time one of your responses corresponds to the command assurers. Give yours self and paint then add u the total number of paint for your scores.

1. True	**6**	**F**	**11**	**T**
2. False	**7**	**F**	**12**	**F**
3. F	**8**	**T**	**13**	**T**
4. F	**9**	**T**	**14**	**T**
5. F	**10**	**T**	**15**	**F**

The nature for inter berthing your score and this scale are bared and a sample of 1,2,71 adults cited by lonetlo and Templar (1983).

High score – 9-15

Medium score – 4-8

Table no. 1.1, 2x2 ANOVA Analysis summary of Death anxiety with reference to types of patients and sex of the cancer patients (N=200)

Source of variance	Sum of Square	df	Mean Sum of Square	F
Types of patients (A)	0.00	1	0.00	0.00 (NS)
Sex(B)	9.68	1	9.68	1.03 (NS)
T of P (A)× Sex (B)	144.50	1	144.50	15.12 (0.01)
SSW(Error)	1872.84	196	9.55	
SST	2027.02	199		

Table no. 1.2, Difference between mean scores of Death anxiety with reference to types of patients and sex of the cancer patients (N=200)

Independent variable	n	Mean(M)	Difference between mean
Pre operated cancer patients	100	8.57	0.00
Post operated cancer patients	100	8.57	
Male	100	8.79	0.44
Female	100	8.35	

With reference to types of cancer patients

Null hypothesis Ho.No.1 was constructed to get information whether any significant difference exist Death anxiety of pre and post operated cancer patients.

Ho.1:- There is no difference between Death anxiety of pre and post operated cancer patients.

It can be observed that the table no. 1.1 that "F" value with reference to Death anxiety of pre and post operated cancer patients was 0.00 this "F" value is not significant. So, null hypothesis 1 is accepted. And the result shows not significant difference. It can be seen the table no. 1.2 that the mean of scores of pre and post operated cancer patients were 8.57 and 8.57 respectively. The difference between mean of Death anxiety of pre and post operated cancer patients is 0.00. So it can be no difference between Death anxiety of pre and post operated cancer patients.

Death anxiety with reference to sex of the cancer patients

Null hypothesis Ho.No.2 was constructed to get information whether any significant difference between male and female of the cancer patients.

Ho.2:- There is no difference between Death anxiety of male and female of the cancer patients.

It can be seen the table no. 1.1 that "F" value with reference to religious behaviour of male and female was 9.68 this "F" value is not significant. So, null hypothesis 2 is accepted. The result shows not significant difference. And it can be seen the table no.1.2 that the mean scores of Death anxiety of male and female were 8.79 and 8.35 respectively. The difference between mean of Death anxiety of male and female is 0.44. So it can be said that there is wide difference between mean of male and female on their death anxiety.

Death anxiety with reference to interaction between types of patients and sex of the cancer patients

Null hypothesis Ho.No.3 was constructed to get information whether any effect exist on Death anxiety as a result of interaction to each other types of patients and sex of the cancer patients.

Ho.3:- There is no interaction effect of Death anxiety on types of patients and sex of the cancer patients.

"F" value obtained while examining hypothesis to get information regarding effect of interaction with reference to Death anxiety of types of patients and sex of the cancer patients. It can be seen the table no.1.1 the "F" value is 15.12 this "F" value is significant at 0.01 levels. So above null hypothesis is rejected. And the result show significant effect of Death anxiety on types of patients and sex of the cancer patients.

DEATH ANXIETY, WITH REFERENCE TO AGE, TYPES OF CANCER, TYPES OF EDUCATION, AREA, TYPES OF FAMILY, INCOME

Table no 1.3, Means and SDs of death anxiety with reference to low and medium age of the cancer patients, (N=200)

Age	N	Mean	SD	t
Low	64	8.52	3.30	0.05 NS
Medium	76	8.49	3.18	
NS= Not Significant				

Death anxiety with reference to age of the cancer patients. (Low and medium)

Null hypothesis Ho.No.4 was constructed to get information whether any significant difference between death anxiety of low and medium age of the cancer patients.

Ho.4:- There is no difference between the death anxiety of low and medium age of the cancer patients.

It can be observed the table no. 1.3 that mean scores with reference death anxiety of low and medium age of the cancer patients were 8.52 and 8.49. The difference between "t" values is 0.05. That "t" value is not significant. It can be seen the table no 4.52 there was no more difference between mean of two group. So, null hypothesis 4 is accepted. And the result shows there is negligible difference between low and medium age of the cancer patients on their death anxiety.

Table no 1.4, Means and SDs of death anxiety with reference to low and high age of the cancer patients (N=200)

Age	N	Mean	SD	t
Low	64	8.52	3.30	0.38 NS
High	60	8.73	3.14	
NS= Not Significant				

Death anxiety with reference to age of the cancer patients. (Low and high)

Null hypothesis Ho.No.5 was constructed to get information whether any significant difference between death anxiety of low and high age of the cancer patients.

Ho5:- There is no difference between the death anxiety of low and high age of the cancer patients.

It can be observed the table no. 1.4 that mean scores with reference death anxiety of low and high age of the cancer patients were 8.52 and 8.73. The difference between "t" values is 0.38. That "t" value is not significant. It can be seen the table no 1.4 there was no more difference between mean of two group. So, null hypothesis 5 is accepted. And the result shows there is negligible difference between low and high age of the cancer patients on their death anxiety.

Table no 1.5, Means and SDs of death anxiety with reference to medium and high age of the cancer patients (N=200)

Age	N	Mean	SD	t
Medium	76	8.49	3.18	0.45
High	66	8.73	3.14	NS
NS= Not Significant				

Death anxiety with reference to age of the cancer patients (Medium and high)

Null hypothesis Ho.No.6 was constructed to get information whether any significant difference between death anxiety of medium and highage of the cancer patients.

Ho.6:- There is no difference between the death anxiety of medium and high age of the cancer patients.

It can be observed the table no. 1.5 that mean scores with reference death anxiety of medium and highage of the cancer patients were 8.49 and 8.73. The difference between "t" values is 0.45. That "t" value is not significant. It can be seen the table no 1.5 there was no more difference between mean of two group. So, null hypothesis 6 is accepted. And the result shows there is negligible difference between medium and high age of the cancer patients on their death anxiety.

Table no 1.6, Means and SDs of death anxiety with reference to blood and other's cancer (N=200)

Types of cancer	N	Mean	SD	t
Blood	40	7.13	3.19	3.28
Other's	160	8.93	3.10	(0.01)
0.01 level				

Death anxiety with reference to types of cancer (blood and other's cancer)

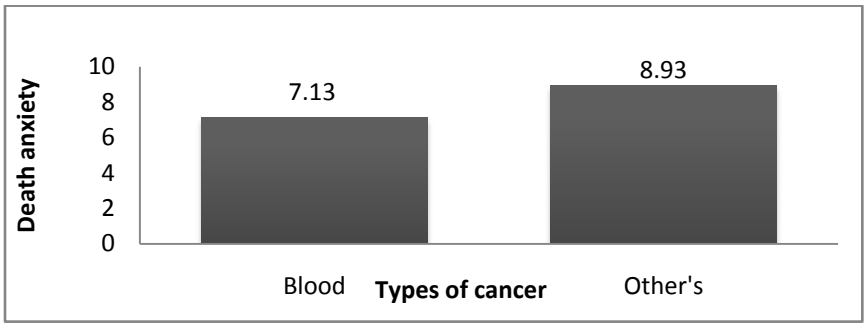
Null hypothesis Ho.No.7 was constructed to get information whether any significant difference between death anxiety of blood and other cancer.

GRAPH

Mean of Death anxiety with reference to blood cancer and other's cancer patients.

X = types of cancer (blood & other's cancer)

Y = 1 cm = 2 average score



Ho.7:- There is no difference between the death anxiety of blood and other cancer.

It can be observed the table no. 1.6 that mean scores with reference death anxiety of blood and other cancer were 7.13 and 8.93. The difference between "t" values is 3.28. That "t" value is significant at 0.01 level. It can be seen the table no 1.6 there was no more difference between mean of two group. So, null hypothesis 7 is rejected. And the result shows there is negligible difference between blood and other cancer on their death anxiety.

Table no 1.7, Means and SDs of death anxiety with reference to low and medium education of the cancer patients (N=200)

Types of Education	N	Mean	SD	t
Low	61	8.28	3.10	1.28 NS
Medium	94	8.95	3.23	
NS= Not Significant				

Death anxiety with reference to education of the cancer patients (low and medium)

Null hypothesis Ho.No.8 was constructed to get information whether any significant difference between religious behavior of low and medium education of the cancer patients.

Ho.8:- There is no difference between the death anxiety of low and medium education of the cancer patients.

It can be observed the table no. 1.7 that mean scores with reference death anxiety of low and medium education of the cancer patients were 8.28 and 8.95. The difference between "t" values is 1.28. That "t" value is not significant. It can be seen the table no 1.7 there was no more difference between mean of two group. So, null hypothesis 8 is accepted. And the result shows there is negligible difference between low and medium education of the cancer patients on their death anxiety.

Table no 1.8, Means and SDs of death anxiety with reference to low and high education of the cancer patients (N=200)

Types of Education	N	Mean	SD	t
Low	61	8.28	3.10	0.16 NS
High	45	8.18	3.22	
NS= Not Significant				

Death anxiety with reference to education of the cancer patients, (low and high)

Null hypothesis Ho.No.9 was constructed to get information whether any significant difference between religious behavior of low and high education of the cancer patients.

Ho.9:- There is no difference between the death anxiety of low and high education of the cancer patients.

It can be observed the table no. 1.8that mean scores with reference death anxiety of low and high education of the cancer patients were 8.28 and 8.18. The difference between "t" values is 0.16. That "t" value is not significant. It can be seen the table no 1.8there was no more difference between mean of two group. So, null hypothesis 9is accepted. And the result shows there is negligible difference between low and high education of the cancer patients on their death anxiety.

Table no 1.9, Means and SDs of death anxiety with reference to medium and high education of the cancer patients (N=200)

Types of Education	N	Mean	SD	t
Medium	94	8.95	3.23	1.32 NS
High	45	8.18	3.22	
NS= Not Significant				

Death anxiety with reference to education of the cancer patients. (medium and high)

Null hypothesis Ho.No.10 was constructed to get information whether any significant difference between religious behavior of medium and high education of the cancer patients.

Ho.10:- There is no difference between the death anxiety of medium and high education of the cancer patients.

It can be observed the table no. 1.9 that mean scores with reference death anxiety of medium and high education of the cancer patients were 8.95 and 8.18. The difference between "t" values is 1.32. That "t" value is not significant. It can be seen the table no 1.9 there was no more difference between mean of two group. So, null hypothesis 10 is accepted. And the result shows there is negligible difference between medium and high education of the cancer patients on their death anxiety.

Table no 1.10. Means and SDs of death anxiety with reference urban and rural area of the cancer patients (N=200)

Area	N	Mean	SD	t
Urban	62	8.44	3.62	0.40
Rural	138	8.63	2.99	NS
NS= Not Significant				

Death anxiety with reference to area of the cancer patients. (Urban and rural)

Null hypothesis Ho.No.11 was constructed to get information whether any significant difference between death anxiety of urban and rural area of the cancer patients.

Ho.11:- There is no difference between the death anxiety of urban and rural area of the cancer patients.

It can be observed the table no. 1.10 that mean scores with reference death anxiety of urban and rural area of the cancer patients were 8.44 and 8.63. The difference between "t" values is 0.40. That "t" value is not significant. It can be seen the table no 1.10 there was no more difference between mean of two group. So, null hypothesis 11 is accepted. And the result shows there is negligible difference between urban and rural area of the cancer patients on their death anxiety.

Table no 1.11

Means and SDs of death anxiety with reference to joint and nuclear family of the cancer patients (N=200)

Types of Family	N	Mean	SD	t
Joint	95	7.98	2.94	2.53 (0.05)
Nuclear	105	9.11	3.33	
0.05level				

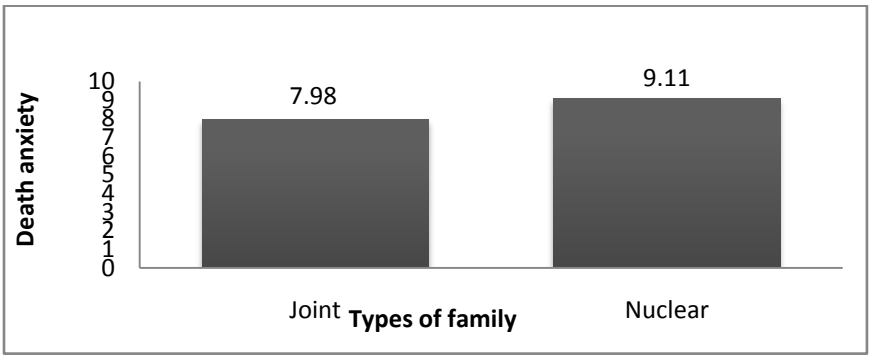
Death anxiety with reference to family of the cancer patients. (Joint and nuclear)

Null hypothesis Ho.No.12 was constructed to get information whether any significant difference between death anxiety of joint and nuclear family of the cancer patients.

Mean of Death anxiety with reference to joint and nuclear family of the cancer patients.

X = types of family (Joint & nuclear)

Y = 1 cm =1 average mean score



Ho.12:- There is no difference between the death anxiety of joint and nuclear family of the cancer patients.

It can be observed the table no. 1.11 that mean scores with reference death anxiety of joint and nuclear family of the cancer patients were 7.98 and 9.11. The difference between "t" values is 2.53. That "t" value is significant at 0.05 level. It can be seen the table no 1.11 there was more difference between mean of two group. So, null hypothesis 12 is rejected. And the result shows there is wide difference between joint and nuclear family of the cancer patients on their death anxiety.

Table no 1.12, Means and SDs of death anxiety with reference to low and medium income of the cancer patients (N=200)

Age	N	Mean	SD	t
Low	88	8.26	3.25	0.32 NS
Medium	63	8.43	2.97	
NS= Not Significant				

Death anxiety with reference to income of cancer patients (low and medium)

Null hypothesis Ho.No.13 was constructed to get information whether any significant difference between death anxiety of low and medium income of the cancer patients.

Ho.13:- There is no difference between the death anxiety of low and medium income of the cancer patients.

It can be observed the table no. 1.13 that mean scores with reference death anxiety of low and medium income of cancer patients were 8.26 and 8.43. The difference between "t" values is 0.32. That "t" value is not significant. It can be seen the table no 1.12 there was no more difference between mean of two group. So, null hypothesis 13 is accepted. And the result shows there is negligible difference between low and medium income of the cancer patients on their death anxiety.

Table no 1.13, Means and SDs of death anxiety with reference to low and high income of the cancer patients (N=200)

Age	N	Mean	SD	t
Low	88	8.26	3.25	1.79 NS
High	49	9.31	3.31	
NS= Not Significant				

Death anxiety with reference to income of the cancer patients (low and high)

Null hypothesis Ho.No.14 was constructed to get information whether any significant difference between death anxiety of low and high income of the cancer patients.

Ho.14:- There is no difference between the death anxiety of low and high income of the cancer patients.

It can be observed the table no. 1.13 that mean scores with reference death anxiety of low and high income of the cancer patients were 8.26 and 9.31. The difference between "t" values is 1.79. That "t" value is not significant. It can be seen the table no 1.13 there was no more difference between mean of two group. So, null hypothesis 14 is accepted. And the result shows there is negligible difference between low and high income of the cancer patients on their death anxiety.

Table no 1.14, Means and SDs of death anxiety with reference to medium and high income of the cancer patients (N=200)

Age	N	Mean	SD	t
Medium	63	8.43	2.97	1.48 NS
High	49	9.31	3.31	
NS= Not Significant				

Death anxiety with reference to income of the cancer patients (medium and high)

Null hypothesis Ho.No.15 was constructed to get information whether any significant difference between death anxiety of medium and high income of the cancer patients.

Ho.15:- There is no difference between the death anxiety of medium and high income of the cancer patients.

It can be observed the table no. 1.14 that mean scores with reference death anxiety of medium and high income of the cancer patients were 8.43 and 9.31. The difference between "t" values is 1.48. That "t" value is not significant. It can be seen the table no 1.14there was more difference between no mean of two group. So, null hypothesis 15 is accepted. And the result shows there is negligible difference between medium and high income of the cancer patients on their death anxiety.

REFERENCE:

1. Pasquini, M., &Biondi, M. (2007), Depression in cancer patients: A critical review. Clinical Practice and Epidemiology in Mental Health, 3(2), 1745-0179
2. Rodgers, J., Martin, C., Morse, R., Kendell, K., &Verrill, M. (2005),An investigation into the psychometric properties of the Hospital: Anxiety and Depression Scale in patients with breast cancer. Health and Quality of Life Outcomes, 3, 41.
3. Sigal, J., Ouimet, M., Margolese, R., Panarello, L., Stibernik, V., &Bescec, S. (2008). How patients with less-advanced and more-advanced cancer deal with three death-related fears: An exploratory study. Journal of Psychosocial Oncology, 26(1), 53-68.
4. Tavoli, A., Montazerim A., Roshan, R., Tavoli, Z., &Melyani, M. (2008), Depression and quality of life in cancer patients with and without pain: The role of pain,beliefs. BioMed Central Cancer, (8)177, doi: 10.1186/1471-2407-8-177to manage uncertainty and threat associated with political conservatism or ideological extremity? Personality and Social Psychology Bulletin, 33, 989–1007.
5. Vilhauer, R. (2008), A qualitative study of the experiences of women with metastatic
6. Yalom I (2000), Existential Psychology, (trans. Zi Allergy), Istanbul, Kabalci Publications. p.70.
7. Yalom, I. D. (1980),Existential psychotherapy. New York: Basic Books. Zeyrek, E. Y. (2006), Death anxiety and a Taoist orientation in two cultures. Perceptual and Motor Skills, 103, 70–78.

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00228V2I12014
http://www.ijip.in | Oct to Dec 2014

A Study of Befriending and Its Use on Suicide Prevention in India

Amitabh Roy*

ABSTRACT:

The Goal of this study was to understand the concept of Befriending and its effects on Suicide Prevention in India. In view of the above purpose we studied the model of Befriending across the world and in India. The data was collected from 3 NGOs based out of Ahmedabad, Mumbai and Chennai. According to the data in the year 2006, Suicide rates had increased marginally up-to 1,18,11,12. It is observed that there is an increase in Suicide rate more among men than women.

Keywords: *Suicide in India*

INTRODUCTION

Befriending is a fairly new concept in India. It can be done by both an individual and an organization. The aim of this study was to understand Befriending and its methodology and its use and effectiveness on Suicide Prevention in India.

What is Befriending?

"A treatment for Depression or Emotional distress that is "non- Judgmental", mutual & purposeful".

Another definition of "Befriending" is as social support that was "initiated, supported and monitored by an agency" expressly one or more parties to benefit.

Use of Befriending for Suicide Prevention:

A group of volunteers called the Samaritans, begun in England in 1953 by Reverend Chad Varah. The service extended by the Samaritans is simply that of "befriending". The Befriended offers support to the suicidal person with no strings attached. He/she is available to listen and to help in whatever way he/she can, expecting nothing – not even gratitude – in return. Since there founding, the Samartians have spread throughout the British Commonwealth and in many other parts of the world

*The Author is a Masters in Psychology from EIILM UNIVERSITY,8th Mile, Budang, Malabassey, West Sikkim- 737121, India.

© 2014 A Roy; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

OBJECTIVES

1. To understand the concept of Befriending
2. To understand the methodology used in Befriending
3. To find out how it has been helpful for Suicide prevention in India

METHODOLOGY

Befriending by an Individual

1. To offer Emotional support, understanding, patience and encouragement.
2. Engage your friend in conversation, and listen carefully
3. Never disperse feelings of your friend or relative expresses, but point out realities and offer hope
4. Never Ignore comments about suicide, and report them to your friend's relatives, therapist or doctor.
5. Invite your friend or relative out for walks, outings and other activities. Keep trying if he/she declines, but don't push him/her to take on too much too soon. Although diversions and company are needed, too many demands may increase feelings of failure.
6. Remind your friend or relative that with time and treatment, the depression will lift.

In case of an NGO/Centre offering befriending the following methodology/charter is followed:

1. Total Confidentiality is offered
2. Provide Emotional support to people when they are Suicidal
3. The volunteers who serve at the Centre also seek to alleviate misery, loneliness, despair and depression by listening to those who feel they cannot turn to anyone else who would understand and accept them.
4. Contact with the agency does not limit individual freedom, which is further protected by the right to remain anonymous.
5. The fact that someone has been in contact with the Centre whether by telephone, letter, Email, visit or any other means) is confidential, so too is everything revealed by or about the person.
6. The Centre's are nonpolitical and nonsectarian and the volunteers do not seek to impose their own convictions on anyone.
7. The Centre may on certain occasion request the advice of professional consultants.
8. In appropriate circumstances individuals may be invited to consider seeking professional help in addition to the support offered by a Centre.

Things a Centre does not do:

1. No Advise is given to the person – even if the volunteer thinks that he/she has an answer to the person's problems.

2. The Centre does not promise the person that they will undertake any action on their behalf without first discussing it with the person in charge of the agency.
3. The Volunteers do not judge the person or criticize their behavior
4. The Centre does not trace person's details like phone numbers, names, address etc.
5. The Centre does not send for an ambulance without the person's consent (unless, under certain circumstances, the person becomes unconscious).
6. The Centre volunteers do not meet the person or make contact with them outside normal center operating procedures.

NETWORK OF SUICIDE PREVENTION CENTRE USING BEFRIENDING IN INDIA

A member of the Befrienders India network, which comes under the aegis of Befrienders Worldwide having over 400 center's around the world, Befrienders India started11 Helplines spread across 4 cities, they are as follows:

1. SAATH an NGO based out of Ahmedabad
2. JEEVAN an NGO based out of Jamshedpur
3. MAITHRI KOCHI an NGO based out of Kerala
4. PRATHEEKSHA an NGO based out of Kerala
5. SNEHA an NGO based out of Chennai
6. THANAL CALICUT an NGO based out of Calicut
7. SAMARITANS MUMBAI an NGO based out of Mumbai
8. AASRA an NGO based out of Navi Mumbai
9. SUMAITRI an NGO based out of New Delhi
10. ROSHINI an NGO based out of Secunderabad
11. LIFELINE FOUNDATION an NGO based out of Kolkata

All these NGO are non-profit organization entirely run by volunteers who offer emotional support to the distressed, depressed and suicidal. The volunteers seek to alleviate misery, loneliness and despair by listening, in a non-judgmental way, to those who cannot turn to anyone else who would understand and accept them. The caller remains anonymous and everything said to the volunteer remains confidential

Centres are mainly resourced by volunteers. Volunteers are selected, trained, mentored and supported by other experienced volunteers and any necessary relevant professional experts. Centres are mutually supportive and committed to sharing information with other member Centre's, and participating in processes and activities of the network

The work of the network's Centre's is outstanding and vital. Capturing their abilities and achievements in suicide prevention will allow for a global exchange of knowledge and practice, developing new global processes that will improve the quality of their experience as volunteers, and ultimately the service they deliver.

STATISTICS

1. AASRA a NGO based in Navi Mumbai has been working on Suicide Prevention. It started its operations from 13th September 1998. As per them below are the facts and data in regards to Suicide.

- Every 40 seconds a life is lost through suicide (Worldwide as per WHO data). Suicide Rate (India 2006-07): General Population-11.5 % per lakh. Army-7.5 % per lakh. Mumbai: (As per Police stats) 3 lives lost per day due to suicide. Navi Mumbai As per Police stats) 2 lives lost per week due to suicide
- In India according to National Crime Records Bureau 110,417 people committed suicide in the year 2002, which is 1.8% more than compared to 2001., i.e.; a suicide is committed every five minutes. Seven times that number attempt to take their lives and as for those who feel desperate and unable to cope, the number is mind boggling. More suicides occur between 18 and 45 - in other words in the most productive age group of our society.
- Every 3 seconds a person attempts to die.
- Suicide is one of the top three causes of death among the young in the age group of 15-35 years
- The psychological, social and financial impact of suicide on the family and the society is immeasurable.
- About 1 lakh people die by suicide in India every year.
- 3 people in a day in Mumbai commit suicide.
- 2 in a week in Navi Mumbai commit suicide.
- Each suicide leaves at least 6 people devastated.6 lakhs people become survivors every year in India.
- Suicide estimates suggest fatalities worldwide could rise to 1.5 million by 2020. Suicide is a largely preventable public health problem, causing almost half of all violent deaths as well as economic costs in the billions of dollars, says the WHO.

Dr Catherine Le Gals-Camus, WHO Assistant-Director General, Non-communicable Diseases and Mental Health said: "World-wide, more people die from suicide than from all homicides and wars combined. There is an urgent need for coordinated and intensified global action to prevent this needless toll. For every suicide death there are scores of family and friends whose lives are devastated emotionally, socially and economically."

- Suicide rates tend to increase with age, but there has recently been an alarming increase in suicidal behaviors amongst young people aged 15 to 25 years old, worldwide. With the exception of rural China, more men than women commit suicide, although in most places more women than men attempt suicide.
- Some [pointers regarding stress and depression and suicide culled from The WEEK magazine. 2008 survey) Mid-year special.
- Under High stress your biological age can be 30 times higher than your calendar age.

- 69% of people suffering from stress related disorders such as depression were apprehensive that society would consider them to be crazy.55 % of people suffering from stress related disorders say they have no or very few close friends.71% people under stress refrain from social activities.50% of people under stress say they are not able to pursue leisure activities or hobbies.
- The typical age of onset of social anxiety disorder is 12 to 19
- 77% people under stress say anxiety or disorders such as insomnia or depression hamper their romantic relationships.
- 58% are embarrassed to acknowledge that they are depressed.
- 35% people suffering from social anxiety disorder say they avoid intimacy with partners.
- A study says 72% writers, 42% artists, 41% politicians, 36% intellectuals, 35% musicians and 33% scientists are prone to stress related disorders.
- Depression among the youth has increased from 2% to 12% in the last five years. Globally 3 out of every 5 visits to the doctor are for stress related problems. 76% people under stress say they have sleeping disorders and 58% suffer headaches. Laughing helps ease stress. And laughing 100 times equals 10 minutes of working out on a rowing machine or 15 minutes of cycling. 85% of people under stress tend to have strained relations with family and friends. 70% of people under stress say they have become short-tempered. A NIMHANS study says 36 % techies in Bangalore show signs of psychiatric disorder. Globally 1 out of every 10 students suffer significant distress. Over 50% of lost workdays across the world are due to stress, says an ILO study. 16000 students in India committed suicide between 2004 and 2008
- According to reports 50% employees in India Inc are under stress :30% have problems such as addictions and marital discord.20% suffer from depression.
- Depression is the No 1 occupational disease of the 21st century says WHO. 49% of people under stress say they suffer from upset stomach or nausea. 71% people undress stress feel they are not productive and cry regularly.
- Over 50% of the World's children are brought up in stressful conditions, says UNESCO. 1 in every 20 IT professionals contemplates suicide , says NIMHANS study. The US govt spends $ 3 billion per year on stress related issues such as compensation claims, medical expenses and reduced productivity.
- Children laugh about 300 times a day while adults laugh only 15 to 100 times. India currently has only about 3500 psychiatrists. Analysts say there must be at least a threefold increase in strength to help a growing tribe of people suffering from stress related disorders.
- 66% CEO's in India are stressed out and 11% find it too much to handle says ASSOCHAM.72% of students in India are unaware of how to deal with stress and it's ill-effects. In 2006 alone 5,857 students committed suicide owing to exam stress.27.6% of IT professionals in India are addicted to narcotic drugs says a NIMHANS study.

2. SNEHA an NGO based in Chennai has been working in the field of suicide intervention for the past 25 years. Since its inception in 1986, over 1,50,000 people have utilized there services**.**

SUICIDE STATISTICS

Year	CHENNAI			TAMIL NADU			INDIA			Rate
	Male	Female	Total	Male	Female	Total	Male	Female	Total	
1992									80149	9.24
1993									84244	9.53
1994									89195	9.91
1995									89178	9.74
1996						9003			88241	9.47
1997						9197			95829	10.03
1998									104713	10.79
1999			1142	6644	4804	11448			110587	11.21
2000	685	399	1084	6769	4207	10976	66032	42561	108593	10.84
2001	646	444	1090	7149	4190	11339	66314	42192	108506	10.57
2002	851	510	1361	6983	4261	11244	69332	41085	110417	10.51
2003	749	489	1238	7154	4718	11872	70221	40630	110851	10.4
2004	663	533	1196	7946	4893	12839	72651	41046	113697	
2005	1333	942	2275	7507	4569	12076	72916	40998	113914	
2006	1501	926	2427			12381	75702	42410	118112	11.3
2007	1534	779	2313	8687	5124	13811	79295	43342	122637	10.8
2008	818	491	1309	9043	5382	14425	80544	44473	125017	10.8
2009	909	503	1412	8950	5474	14424	81471	45680	127151	10.9

CONCLUSION

Befriending is fairly a new concept in India; it is a tool that has been regularly used by Catholic institutions, NGO's, Government agencies across the globe and in India to counsel people. The concept of Suicide Prevention Centre's is not more than a decade old in our country and is spreading across our nation. Currently we have about 11 centers run by Befrienders India network spread across the country. Befriending is an effective tool which has helped people to gain trust in themselves and helped them to come out of depression and lead a normal life. It has been successful in preventing suicide attempts in more than 90% of cases which have been handled by these centers in India and abroad. But keeping in view of the increasing suicide rates there is a need of more such suicide prevention Centre's in India. The Government needs to set up or collaborate with such institutions and help them reach more people who are in need of their services. Befriending alone cannot help people having depression, but can give them a temporary relief from their current burning situation. A professional help is always helpful in cases where suicidal tendencies are seen. Befriending cannot be termed as a therapy but could be a stop gap

solution to the problem he/she is facing. It helps the person to realize his/her current situation and helps him/her to take out time and think on the problems he/she is facing and to some extent gives them the strength and courage to face their issues/problems with a more practical approach.

REFERENCES & SOURCES

1. AASRA an NGO based in Navi Mumbai, working on Suicide Prevention
2. Abnormal Psychology and Modern Life by James C Coleman; Chapter 17, Suicide, page no 603
3. BEFRIENDERS WORLDWIDE
4. Irene S Levine, PhD in the Friendship Doctor - "Is Befriending a treatment for depression?" – Published on Feb 7, 2010
5. SAATH an NGO based in Ahmedabad, working on Suicide Prevention
6. SNEHA an NGO based in Chennai, working in the field of suicide intervention

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00229V2I12014
http://www.ijip.in | Oct to Dec 2014

Reasons for Living of Elderly in Old Age Homes: An Exploratory Study

Shamsi Akbar*, S.C.Tiwari**, Rakesh Kumar Tripathi***, Ambrish Kumar****, Nisha Mani Pandey*****

ABSTRACT:

Background: Now-a-days, almost all the old age homes (OAHs) in India are fully occupied with residents. Why Indian elderly have to reside in old age homes? It was explored during the Ph.D. study titled 'A Study of Psychiatric Morbidity, Quality of Life and Expectations of Inmates of Old Age Homes in Northern India'. The object of this study was to explore the factors compelling elderly to reside in old age homes.

Methods: This study was carried out on 174 elderly residing in 14 different OAHs of Uttar Pradesh, India. Factors responsible for their settlement in OAHs were explored using interview method.

Results: Misbehaviour of son and daughters-in-law (29.8%) was found to be most common reasons for residing in old age home.

Conclusions: Many elderly in India are opting OAHs as their place of stay in their later life. Foreseeing the future the government and voluntary agencies in India must make arrangements for institutional support and care for the elderly.

Keywords: *Old age home, elderly, compelling factors, exploratory study.*

INTRODUCTION

Population ageing is one of the most discussed global phenomena in the present century. Countries with a large population like India have a large number of people now aged 60 years or more. The population over the age of 60 years has tripled in last 50 years in India and will relentlessly increase in the near future.

*Research Scholar, Corresponding author, King George's Medical University, UP, Lucknow, India

**Professor & Head, King George's Medical University, UP, Lucknow, India

***Assistant Professor, King George's Medical University, UP, Lucknow, India

****Social Worker, King George's Medical University, UP, Lucknow, India

*****Senior Research Officer, King George's Medical University, UP, Lucknow, India

© 2014 S Akbar, S Tiwari, R Tripathi, A Kumar, N Pandev; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

According to census 2001, older people were 7.7% of the total population, which increased to 8.14% in census 2011. The projections for population over 60 years in next four censuses are: 133.32 million (2021), 178.59 (2031), 236.01 million (2041) and 300.96 million (2051). The increases in the elderly population are the result of changing fertility and mortality regimes over the last 40-50 years (Ministry of Health and Family Welfare, 2011) & (Central Statistics Office, New Delhi, 2011). With the rapidly increasing number of aged, the care of elderly has emerged as an important issue in India. Providing care for the aged has never been a problem in India where a value based joint family system was dominant. This family structure has been the socio-economic backbone of the average Indian (Shah, 1998). During ill health or emergency or any critical position, family members were taking the responsibilities and sharing the burden to help each other. The families also were sharing the responsibility to look after their elderly by giving them all kind of support including emotional, psychological, behavioural or economic. They were getting full respect and value. Their advices were also being received by younger generation and were revered and honoured. They were living in the family till the end of their life. With the increasing influence of modernization and new life styles resulting in transitional changes in value system in recent times, the 'joint family' is breaking down into several scattered nuclear families (Shah, 1998). Change in family structure and contemporary changes in the psycho-social matrix and values often compel the elderly to live alone or to shift from their own homes to some institutions or old age homes (Dotty, 1992, Hegde et al, 2012, Kumar et al, 2012, Devi et al, 2013, Mishra, 2008 & Mudey et al, 2011). OAHs are coming in existence as a newer occupancy for elderly and becoming the need of present Indian society. The recent data shows that there are more than 1,000 old age homes in India and most of them are located in the south India. There are of two types of old age homes: free and paid. The "free" type care homes are for the destitute old people who have no family to care and support for them. In such OAHs shelter, food, clothing and medical care etc. are being provided free of cost. In the paid type, all types of services are available for a price.

However, hardly studies explored the factors responsible to compel elderly to reside in OAHs. Therefore, an attempt was made to explore factors responsible to force elderly to reside in OAHs leaving their own homes.

METHOD:

Study Location: Old age homes of district Bareilly, Lucknow and Varanasi.
Study Design: Cross-sectional exploratory study.
Sample size: A total of 174 elderly residing in OAHs were included in the study.
Inclusion criteria: (a) elderly aged 60 years and above residing in old age homes and able to communicate. (b) Staying in old age homes since six months or more. (c) Able to understand, comprehend and reply to questions and (d) given written informed consent.
Exclusion criteria: (a) Non-cooperative due to any reason (b) any physical problems interfering with interview (e.g. problem in Speech, Hearing, and Vision).

Assessment Tool: Semi-structured proforma to gather socio-demographic details and an open ended question to solicit the factor responsible for their stay in OAHs.

Procedure: This study is a part of the Ph.D. study titled "a study of psychiatric morbidity, quality of life and expectations of inmates of Old Age Homes in Northern India". The study is being carried out in the Department of Geriatric Mental Health, King George's Medical University, Lucknow. Initially, a total of 21 old age homes from Bareilly (3), Lucknow (5), and Varanasi (13) districts were identified by Help Age India Old Age Homes Directory 2009 and local resources. Out of the 21 old age homes, 5 were non-existent in Varanasi. The researcher has approached the concerning authorities of these 16 identified old age homes and briefed about the purpose of the study but 2 of them have refused to give consent for the study. The reasons for non-cooperation were (i) the study will take time and (ii) the study will involve an extra man-power from the old age home. So, a total of 14 old age homes were selected. A total of 258 elderly residents from these old age homes were screened for the study. Eighty four of them were excluded as per inclusion/exclusion criteria and 174 subjects were screened as the study sample. After initial rapport building and seeking written informed consent, the socio-demographic details were obtained on a semi-structured proforma. To explore the reasons/factors compelled them to shift from their own homes to the OAHs an interview was done. Data was analyzed using percentage statistics.

RESULTS:

A total of 174 older adults participated in the study. Table 1 provides their socio-demographic details.

Table-1: Socio-demographic profile of OAH residents

Socio-demographic details		**Gender**		**Total (N=174)**
		Male (N=44, 25.3%)	**Female (N=130,74.7%)**	
Age (Mean: 72.8 yrs)	60-69	14 (19.2%)	59 (80.8%)	**73 (41.9%)**
	70-79	11(19.6%)	45 (80.4%)	**56 (32.2%)**
	80 year & above	19 (42.2%)	26 (57.8%)	**45 (25.9%)**
Education (Mean: 6.6 yrs)	Illiterate	05 (7.9%)	58 (82.1%)	**63 (36.2%)**
	Up to 8th	09 (20.9%)	34 (79.1%)	**43 (24.7%)**
	Up to 12th	08 (25.8%)	23 (74.2%)	**31 (17.8%)**
	Graduate and above	22 (59.4%)	15 (40.6%)	**37 (21.3%)**
Marital	Married Living	14 (8.0%)	22 (12.6%)	**36 (20%)**

Status	Alone			
	Married Living together	08 (4.5%)	08 (4.5%)	**16 (9.1%)**
	Never married	05 (33.3%)	10 (66.7%)	**15 (8.6%)**
	Widow/widower	15 (15%)	85 (85%)	**100 (57.5%)**
	Divorced	02 (28.6%)	05 (71.4%)	**07 (4.0%)**
Occupation	Household work (no productive work for male)	10 (8.1%)	113(91.9%)	**123 (70.7%)**
	Pensioner	25 64.1%)	14 (35.9%)	**39 (22.4%)**
	Business /others	09 (75%)	03 (25%)	**12 (6.9%)**

Socio-demographic indicators included Age, Gender, Educational level, and Occupational and marital status. Mean Age of the sample was 72.8 yrs while mean of the education was 6.6 yrs. Socio-demography details showed that most of the OAHs residents were females (74.7%), aged between 60-69 years (41.9%), either illiterate or educated only up to 8th (60.9%), widow/widower (57.5%) and were involved in household work (70.7%).

Table-2- Factors compelling elderly to reside in old age homes

S.No	**Factors**	**No (%)**
1	Misbehaviour of son and daughters-in-law	52 **(29.8%)**
2	Poverty/ no financial support	51 **(29.3%)**
3	To serve the almighty God	16 (9.1%)
4	Loneliness	14 (8.0%)
5	Adjustment problem	10 (5.7%)
6	Nuclear family system	09 (5.1%)
7	Having no son	09 (5.1%)
8	Settlement of children at abroad	04 (2.2%)
9	Children do not want to keep due to psychiatric and/or physical illness	04 (2.2%)
10	Life threats from children	03 (1.7%)
11	To live independently/ unable to tolerate interference of family members	02 (1.1%)

The factors compelled the OAHs residents for residing in old age homes are provided in table-2. The most common reasons were misbehaviour of children (29.8 %) and poverty/no financial support (29.3%). Other factors were to serve the almighty GOD (9.1%), loneliness (8.0%), adjustment problem (5.7%), nuclear family system (5.1%), having no son (5.1%), children settled in abroad (2.2%), children do not want to keep the elderly due to their physical & psychiatric illness (2.2%), life threats from children (1.7%) and better facility in old age home (1.1%).

DISCUSSION:

Majority of the old age home residents were aged between 60-69 years which is similar to the study done by Hegde et al, (2012). Majority of the elderly were females, either illiterate or educated up to 8th and widow/widower, similar findings were obtained by a previous study (Tiwari et al, 2012). Most of the female inmates of OAHs said that they were house wives and spent their whole time in doing house hold works and were having no financial gains for their livelihood which forced them to depend on their family. This was the major factor which compelled them to opt OAHs for rest of their life.

A number of studies have discussed various reasons for the elderly to be in old age home. Lack of care in the family, insufficient housing, economic hardship and break-up of joint family are cited as reasons by studies carried out by Bansod et al, (2006), Bharati, (2009) and Mishra et al, (2008). Present study reports "misbehaviour of children" (29.8%) as most common factor for residing in old age home, is supported by the study done by Lalan, (2014) and Gupta et al, (2014). In this study, the OAHs residents, who reported "poverty" as the reason, was mainly belonging to labor class. In their old age, neither they had money nor were they able to earn money due to their weakness and inability to work. Their children were also doing the same job and they were not in condition to support their parents. That's why they had to come to the old age home for living. "Poverty" (29.3%) as the reason for living in old age homes is also supported by many of the studies carried out by Lalan, (2014), Gupta et al, (2014), Siddhu et al, (2010) and Gurushekhran, (2008). "Having no sons" was also found to be a factor, mentioned by residents for coming to OAHs; these inmates informed that they were having daughters to look after. They further explained that they did not want to live with their married daughters as it is believed that a parent who lives with married daughter will not get relief (Moksha) after death. Therefore, they have opted OAHs as their residence. Similar findings were obtained by Siddhu, (2010) and Lalan, (2014). "To serve the almighty GOD", cited as one of the reasons specifically by the residents of OAHs in Varanasi, which is believed as religious capital among the Hindus. The Hindu devotee come here for prayer and spiritual pursuits in last phase of life and wish to die at this place because it is believed as "door to heaven". This finding is supported by Panigrahi et al, (2012) and Gupta et al, (2014). Elderly residents mentioning "loneliness" as the reason, is supported by the study by Dubey et al, (2011) and Gupta et al, (2014). "Adjustment problem" is supported by the study done by Siddhu, (2010). "Settlement of children at abroad" is again supported by the study by Gupta et al, (2014). Nuclear Family System has also been expressed as one of the reasons for shifting to old age homes. The tradition of joint family in the

culture of Indian society is disappearing slowly, which was based on the love, affection and tradition. It has also transformed the life of family. People have started believing in "Nuclear family" rather than combined or joint. It has made people to live with his own family which including husband, wife and their children. This culture has also affected the emotion of each individual person. In today's time parents afraid from their children, that's why they have started refusing to live with them (children). Due to this reason they have started moving in the old age home (Lalan, 2014). The resident, who belonged to the well to do section of the society, stated that they came to the old age home to lead an independent and peaceful life without any interference. This finding is supported by Panigrahi et al, (2012).

CONCLUSION:

Misbehaviour of children, financial crisis often lead to feeling of ignorance and lack of emotional support in elderly which often compel them to opt other places for living a problem free life. And, in present scenario along with other reasons OAHS are being considered as a better alternative to reside. There is a need to generate emotional support facilities in these homes and the government and voluntary agencies in India must make arrangements for institutional support and care for the elderly.

Conflict of interest declaration: The authors declare that they have no conflict of interest.

Description of authors' roles: SA: Ph.D. student, collected, analysed, interpreted the data and drafted the manuscript. SCT: Ph.D. guide, conceptualised and designed the study, gave comments on the drafts of the manuscript. RKT: Ph.D. co-guide, conceptualised and designed the study, gave comments on the drafts of manuscript. AK: searched the related literature, analysed and interpreted the data and edited the manuscript. NMP: Ph.D. co-guide, conceptualised and designed the study, gave comments on the drafts of manuscript. All authors approved the final manuscript.

ACKNOWLEDGEMENTS:

The authors are thankful to the administrative personnel of the OAHs for their cooperation in the study. Authors also greatly appreciate the OAHs residents for participating in the study.

REFERENCE:

1. Bansod, D., Paswan, B. (2006). From Home to Old Age Home: A Situational Appraisal of Elderly in Old Age Home in Maharashtra. Help Age India Research and Development Journal; 12 (3): 14-23.
2. Bharati, K. (2009). Old Age Homes: New Face of Old Age Care in India. Help Age India Research and Development Journal; 15 (2): 13-18
3. Central Statistics Office, Ministry of Statistics and Programme Implementation, Government of India, New Delhi, (2011). Situation Analysis of the Elderly in India.

4. Director General of Health Services, Ministry of health & family welfare, Government of India, New Delhi. (2011). National Program for Health Care of the Elderly.
5. Dotty, P.J. (1992). The oldest old and the use of institutional long term care from an international perspective. In The oldest old (eds. R. Suzman, DP Willis, KG Manton). New York: Oxford University Press; 250-259.
6. Dubey, A., Bhasin, S., Gupta, N. & Sharma, N. (2011). A study of elderly living in old age home and within family set-up in Jammu, Studies on Home Community Science; 5(2): 93-98
7. Gupta, A., Mohan, U., Tiwari, S.C., Singh, S.K., & Singh, V.K. (2014). Quality of life of elderly people and assessment of facilities available in old age homes of lucknow, India. National Journal of Community Medicine; 5(1): 21-24.
8. Hegde V.N, Kosgi S., Rao S., Pai. N & Mudgal S.M. (2012). A Study of Psychiatric and Physical Morbidity among Residents of Old Age Home. International Journal of Health Sciences & Research; 2(1): 57-74.
9. Kumar,P., Das A., Rautela U. (2012) Mental and Physical Morbidity in Old Age Homes of Lucknow, India. Delhi Psychiatry Journal; 15(1): 111-117.
10. Lalan, Y. (2014**)**. A Sociological Study of Old Persons Residing in an Old age Home Delhi, India. International Research Journal of Social Sciences; 3(4): 21-23,
11. McConnel, C.E. (1984). A note on the life time risk of nursing home residency. Gerontology; 24(2): 193-198.
12. Mishra,Jayanta, A. (2008). A Study of the Family Linkage of the Old Age Home Residents in Orissa. Indian Journal of Gerontology; 22 (2): 196-212.
13. Mudey, A., Ambekar S., Goyal, R.C., Agarekar, S.,Wagh, V.V. (2011). Assessment of Quality of Life among Rural and Urban Elderly Population of Wardha District, Maharashtra, India. Ethno Med; 5(2): 89-93.
14. Murtaaugh C.M., Kemper, P., & Spillman, B.C., (1990). Risk Factors of Nursing Home Use in Later Life. Med Care; 28(10): 952-962.
15. Panigrahi, A.K., Syamala, T. S. (2012). Living Arrangement Preferences and Health of the Institutionalised Elderly in Odisha. ISEC Working Paper Series; 291.
16. S, Gunasekaran., S,Muthukrishnaveni. (2008). Living Condition and Health Status of Elderly in Old Age Homes. Helpage india Research & Development Journal; 14 (3): 8-18.
17. Shah, A.M. (1998). The Family in India: Critical Essays. Orient Longman Limited.
18. Sidhu, G.V. (2010). Helpage India Research & Development Journal; 16(2): 24-31.
19. Tiwari, S.C., Pandey, N. M., Singh. I., (2012). Mental health problems among inhabitants of old age homes: A preliminary study. Indian Journal of Psychiatry; 54(3): 6-10.

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00230V2I12014
http://www.ijip.in | Oct to Dec 2014

Differences of thought

Dr. Thiyam Kiran Singh*, Ajaz Ahmad**, Akshat Chowdhury***

ABSTRACT:

The current study is about thought disorder and its kinds. Disorder of thought refers to the disturbance in one's thoughts. There are many types of thought disorders. Broadly, thought disorders are classified into four main categories: stream, possession, content and form. The study is regarding these four main categories as well as the other types of disorders of thought that may be regarded as their sub-categories. The authors have tried hard enough to explain each type of disorder of thought with the help of an example, making the comprehension easy especially for those who don't know much about thought disorders. Furthermore, the authors have tried to illustrate different types of thought disorders using the illustrative pictures. The authors have gathered information through available manuscripts as well as internet.

Keywords: *Disorders, Thought, Stream, Possession*

INTRODUCTION

Personality is the superstructure of the relatively consistent and enduring innate learned, apparent hidden characteristics of an individual like physical appearance, attitudes and behaviour that combine together and influence one's way of interaction with the environment (Ahmad, 2012). Differences of thought also influence personality and that makes difference of one personality to another personality. Disorder of thought refers to the disturbance in the processing, organization and relevance of thoughts manifested as illogical, bizarre, unorganized and irrelevant language or communication. Frank Fish, the first professor for Psychiatry at the University of Liverpool, in 1967, classified disorder of thought into: stream, possession, content and form. Disorder of Stream has two main categories: (1) Disorder of Tempo and (2) Disorder of Continuity. Disorder of Tempo is further divide into: (i) Flight of Ideas (ii) Retardation of Thinking and (iii) Circumstantialities. Disorder of Continuity is divided into: (i) Perseveration and (ii) Thought Blocking. Disorder of Possession has two main categories: (1) Obsession and Compulsion and (2) Thought Alienation. Thought Alienation is further divided into: (i) Thought Insertion (ii) Thought Withdrawal (iii) Thought Broadcasting and (iv) Thought Echo. Disorder of Content is categorized into: (1) Phobias (2) Religious Preoccupations (3) Ideas of Hopelessness

*Assistant Professor and Clinical Psychologist, Dept. of Psychology, AIBAS, Amity University Rajasthan, Jaipur. India | **&***M.Phil Clinical Psychology trainee, Dept. of Psychology, AIBAS, Amity University Rajasthan, Jaipur.

© 2014 K Singh; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

(4) Ideas of Worthlessness (5) Suicidal Ideas (6) Hypochondriacally Ideas (7) Depersonalization (8) Serialization (9) Antisocial Urges (10) Homicidal Ideas and (11) Delusions. Karl Jaspers categorized delusions as: (i) Primary Delusions and (ii) Secondary Delusions. Primary delusions include: (a) Delusional Intuition (b) Delusional Perception (c) Delusional Atmosphere and (c) Delusional Memory. Secondary delusions include: (a) Delusion of Control (b) Nihilistic Delusion (c) Delusional Jealousy (d) Delusion of Guilt (e) Delusion of Mind being Read (f) Delusion of Thought Insertion (g) Delusion of Reference (h) Erotomania (i) Religious Delusion (j) Somatic Delusion (k) Delusion of Poverty (l) Delusion of Persecution (m) Delusion of Grandeur (n) Delusion of Infidelity (o) Delusion of Recognition and (p) Delusional Misidentification Syndrome. Delusional misidentification syndrome further comprises Capgras Delusion, Fregoli Delusion, Intermetamorphosis and Subjective Doubles. Disorder of Form consists of: (1) Loosening of Associations (2) Derailment (3) Neologisms (4) Desultory Thoughts (5) Drivelling (6) Omission (7) Clang Associations and (8) Word Salad.

CONTENT:

Disorder of Thought:

Disorder of thought refers to any disturbance in the processing, organization and relevance of thoughts manifested as illogical, bizarre, unorganized and irrelevant language or communication. Thought disorder is the hallmark feature of many psychological disorders especially the psychotic disorders like schizophrenia. Manifestation of thought disorder ranges from simple blocking and mild circumstantialities to profound loosening of association, incoherence and delusion, characterized by a failure to follow semantic and syntactic rules that is inconsistent with the person's education, intelligence or cultural background.

People who suffer from thought disorders often have difficulty with the flow, control, subject matter and organization of thoughts. They may be unable to express thoughts in a logical fashion, or they may speak quickly or incoherently. Many individuals also suffer from a disturbance in the way they produce content- this can be seen in individuals having delusions or hallucinations, such as people suffering from PTSD.

Fish (2007) classified disorder of thought into the following categories:

I. Disorder of Stream of Thought: Abnormality in the flow of one's thoughts.

II. Disorder of Possession of Thought: Loss of control over one's thought processing.

III. Disorder of Content of Thought: Abnormality in content or material of thought.

IV. Disorder of Form of thought: Disturbance in the arrangement of thoughts or in the logical connections between ideas.

Let us elaborate this classification of thought disorders in the following manner:

DISORDER OF STREAM OF THOUGHT:

A normal individual has a smooth and continuous flow of thoughts and at the same time he is still able to maintain a tolerable standard in the pace or speed of the flowing thoughts. However, a patient with a disorder of stream of thought finds it very difficult to manage and maintain generally acceptable speed and continuity in his thoughts. Patients with mania, depression and schizophrenia generally possess the disorder of stream of thought. Disorder of stream of thought is of two main types:

• Disorder of Tempo

• Disorder of Continuity

Let us describe them in the following manner:

DISORDER OF TEMPO:

It refers to the abnormality in the speed of the production of one's thoughts. It can be categorised into the following:

a) Flight of Ideas:

A nearly continuous flow of rapid speech that jumps from topic to topic, usually based on discernible associations, distractions, or plays on words, but in severe cases so rapid as to be disorganized and incoherent. It is mostly seen in mania, schizophrenia and ADHD. For example, the patient says, "I like oranges, the water is very cool, America rules the world".

b) Inhibition or Retardation of Thinking:

It refers to the slow speed of speech and prolonged latent period before response. For example, the patient says, "I went to the market (pause)…….. the shop was closed." It is mostly seen in schizophrenia, depression.

c) Circumstantialities:

It occurs when thinking proceeds slowly with many unnecessary and trivial details, but finally the point is reached. For example, when the patient is asked about the bruise on her arm, the patient recounts everything else that happened the same day before explaining how she was injured. It is mostly seen in mania, schizophrenia, organic mental disorders.

2. DISORDER OF CONTINUITY:

It refers to the abnormality in the maintenance of a particular matter of concern while thinking about something. It can be categorized into the following types:

a) Perseveration:

It refers to a disturbance in thought association that is manifested by repetitive verbalisation or persistent repetition of the same ideas in response to different questions. For example, when asked for the current day, the patient says it's Wednesday, but subsequent questions about month, year, and place are all met with the same reply. It is mostly seen in schizophrenia, dementia, etc.

b) Thought blocking:

It refers to the abrupt interruption in the flow of thoughts or ideas resulting from a disturbance in the speed of association. For example, while responding to the query about how he was injured, the patient says, "I went to the market (extreme silence)……." This disorder is mostly seen in schizophrenia, anxiety disorder, etc.

II. DISORDER OF POSSESSION OF THOUGHT:

Normally, one experiences one's thinking as being one's own, although this sense of personal possession is never in the foreground of one's consciousness. One also feels that one is in the control of one's thinking. However, in some psychiatric illnesses, there is a loss of control of sense of possession of thinking. Disorder of possession of thought can be divided into the following categories: (Casey & Kelley, 2007)

• Obsession and Compulsion

• Thought Alienation

These can be described in the following manner:

1. OBSESSION AND COMPULSION (Obsessive Compulsive Disorder, 2014):

It is important to understand the distinction between obsessions and compulsions. Obsessions are recurrent and persistent thoughts, impulses, or images that cause distressing emotions such as anxiety or disgust despite the individual's awareness that the thought is either entirely without purpose or else has persisted and dominated their thinking beyond the point of relevance or usefulness. People with OCD recognize that the thoughts, impulses, or images are a product of their mind and are excessive or unreasonable. Yet these intrusive thoughts cannot be settled by logic or reasoning.

One of the most important characteristic features of obsession is that their content causes the sufferer great anxiety and even guilt. The thoughts are particularly repugnant (disgusting) to the individual like for example; the prudish person is tormented by sexual thoughts, the religious person by blasphemous thoughts and the timid person by thoughts of torture, murder and general mayhem. Generally, nowadays, the most common forms of obsession tend to be concerned with

fears of doing harm e.g., wife with an obsession that she may harm her husband. Most people try to ignore or suppress such obsessions or neutralize them with some other thought or action.

Some typical obsessions include:

(a) Fear of dirt or contamination, (b) Fear of becoming ill, (c) Constant thoughts of a certain number, (d) Need for symmetry or exactness, (e) Worry about whether something has been done "right", (f) Forbidden sexual or religious thoughts

While obsessions are recurring thoughts, compulsions are recurrent actions. Compulsions are repetitive behaviours or actions that the person feels driven to perform in response to an obsession. The behaviours are aimed at preventing or reducing distress or a feared situation. In the most severe cases, a constant repetition of rituals may fill the day, making a normal routine impossible. For example, a person may need to check to see if they locked the doors before going to bed. They may lose sleep continuing to check over and over. Mostly these will be quite mild but in more extreme cases they may develop as a means for people to try to relieve themselves from their obsessive thoughts. For example, when there is an obsession with germs, a person may continually wash their hands, even to the point their hands become raw from so much washing. When a person continues to repeat an action, obsessions may go away for a short period of time, however, they will normally return. Once they return, the compulsion will begin again, starting a cycle of obsession-compulsion.

Some common compulsions include:

(a) Washing hands, (b) Brushing teeth, (c) Blinking eyes , (d) Counting items, such as currency, (f) Checking to see if appliances are turned off, (g) Checking to see if doors are locked, (h) Arranging items in a certain way, (i) Keeping items, such as containers, even if they are no longer needed, (j) Requiring constant approval from people around them.

Obsession occurs in obsession states, depression, schizophrenia, and occasionally in organic states; compulsive features appear to be particularly common in post-encephalitic Parkinsonism (Lishman, 1998).

2. THOUGHT ALIENATION: (Cassey and Kelley, 2007)

This refers to a symptom of psychosis in which the patients have the experience that their thoughts are under the control of an outside agency or that others are participating in their thinking. Any form of thought alienation is a highly indicative feature of schizophrenia. Thought alienation includes the following categories:

(a) Thought Insertion:

In pure thought insertion, the patient knows that thoughts are being inserted into their mind and they recognize them as being foreign and coming from without any stimulus. This symptom is commonly associated with schizophrenia, is not unique to schizophrenia and a range of related

phenomena have also been described. For example, the patient repeatedly complains of having disturbed violent thoughts, which, she claims are being sent to her by alien.

(b) Thought Withdrawal:

Thought withdrawal refers to the delusion that someone or something is removing thoughts from one's mind and the patient has no power over this. For example, the patient continually blames his poor memory on "government agents" who he claims are able to steal his thoughts.

(c) Thought Broadcasting:

Here the patient knows that as they are thinking, everyone else is thinking in unison with them (Fish & Hamilton, 1994). The term "Thought Broadcasting" has also been used to describe the belief that one's thoughts are quietly escaping from one's mind and that other people might be able to access them, and the experience of hearing one's thoughts spoken aloud and believing that, as a result, other people can hear them. For example, the patient believes that the news broadcasted on television or internet actually reflects his own thoughts.

(d) Thought Echo:

In this type of thought disorder, the patient hears the 'echo' of his own thoughts in the form of a voice after he has made the thought. For example, the patient may complain that when he thought of meeting a person in the morning, he heard a voice uttering the same thought aloud.

III. DISORDER OF CONTENT OF THOUGHT:

Normal contents of thought are composed of awareness, ideas, concern, belief, preoccupation, imagination (The Phobia List, 1995).

• Phobia, • Religious Preoccupations • Ideas of Hopelessness • Ideas of Worthlessness • Suicidal Ideas • Hypochondriacally Ideas • Depersonalization • Serialization • Antisocial Ideas • Homicidal Ideas • Sex Preoccupations • Delusions

Now, let us describe these abnormalities in the following manner:

1. PHOBIAS:

A phobia is a type of anxiety disorder, usually defined as a persistent fear of an object or situation in which the sufferer commits to great lengths in avoiding, typically disproportional to the actual danger posed, often being recognized as irrational. In the event the phobia cannot be avoided entirely, the sufferer will endure the situation or object with marked distress and significant interference in social or occupational activities.

Some of the common phobias are:

1. Arachnophobia – fear of spider
2. Barophobia – fear of gravity
3. Cynophobia – fear of dogs
4. Demonophobia, – fear of demons
5. Emetophobia – fear of vomiting
6. Frigophobia – fear of becoming too cold
7. Gephyrophobia – fear of bridges
8. Hemophobia – fear of blood
9. Ichthyophobia – fear of fish
10. Kinetophobia – fear of movement
11. Logophobia – fear of words
12. Melissophobia – fear of bees
13. Nosocomephobia – fear of hospitals
14. Ombrophobia – fear of rain
15. Pyrophobia – fear of fire
16. •Radiophobia – fear of radioactivity or X-rays
17. Scolionophobia – fear of school
18. Thanatophobia – fear of dying
19. Uranophobia – fear of Heaven
20. Vestiphobia – fear of clothing
21. Workplace phobia – fear of the workplace
22. Xanthophobia – fear of the color yellow
23. Zoophobia – fear of animals

2. RELIGIOUS PREOCCUPATIONS:

This refers to the thoughts involving religious themes or subject matter. Individuals experiencing religious preoccupations are anxious with religious subjects that are not within the expected beliefs for an individual's background, including culture, education and known experiences of religion. These preoccupations are incongruous with the mood of the subject. For example, the patient may believe that he gets instructions directly from God. These are found in patients with schizophrenia and psychotic depression.

3. IDEAS OF HOPELESSNESS:

This refers to the thoughts of complete despair where the patient strongly believes that the circumstances will never get better for him. For example, the patient may think that the government will never be able to remove corruption from the society. Such thoughts are commonly found in patients with Generalised Anxiety Disorder and Depression.

4. IDEAS OF WORTHLESSNESS:

When someone feels worthless, they feel as if they are insignificant and have nothing valuable to offer the world. They feel as if their entire life is cast in a negative light with no prospect of improvement. Often, this perception is extremely distorted and is the result of an underlying condition such as depression, anxiety, grief, or stress. For example, the patient says that his life is a complete waste.

5. SUICIDAL IDEAS:

It refers to the thoughts of taking one's own life. Generally, the patients with the thoughts of hopelessness and worthlessness suffer from the thoughts of suicide as well.

6. HYPOCHONDRIACAL IDEAS:

Patients having these ideas become unduly alarmed about any physical or psychological symptoms they detect, no matter how minor the symptom may be and are convinced that they have or are about to be diagnosed with, a serious illness. For example, the patient may be very curious to gather information about different serious diseases and try to correlate his signs with the symptoms.

7. DEPERSONALISATION:

Here, the sufferers feel disconnected from one's physicality or body, feeling detached from one's own thoughts or emotions, feeling as if one is disconnected from reality and a sense of feeling as if one is dreaming or in a dreamlike state.

8. DEREALISATION:

Derealisation is an alteration in the perception or experience of the external world so that it seems unreal. Other symptoms include feeling as though one's environment is lacking in spontaneity, emotional colouring and depth. It is a dissociative symptom of many conditions such as psychiatric and neurological disorders and not a standalone disorder. For example, the patient may complain that the world and the aspects of it are nothing more than a dream.

9. ANTISOCIAL URGES:

This refers to the thoughts of indulging in some behaviours or actions that harm or lack consideration for the well-being of others. Anti-social behaviour is labelled as such when it is deemed contrary to prevailing norms for social conduct. For example, the patient may feel highly motivated to rob a bank or to threaten people for extortion money.

10. HOMICIDAL IDEAS:

Here, the patient has a range of homicidal thoughts which spans from ideas of revenge to detailed and fully formulated plans without the act itself.

11. SEX PREOCCUPATION:

Here, the patient is preoccupied with thoughts of sexual acts or behaviours.

12. DELUSIONS:

Delusions are false beliefs that are strongly held and unchangeable in the face of refuting evidence and that are not consistent with the person's educational, social and cultural background.

The psychiatrist and philosopher Jaspers (1913) define the three main criteria for a belief to be considered delusional in his book General Psychopathology. These criteria are:

i. Certainty (held with complete confidence)

ii. Incorrigibility (not changeable by proof to the contrary)

iii. Impossibility or falsity of content (implausible, bizarre or patently untrue)

Delusions are categorized into the following groups:

i) Bizarre Delusion: A delusion that is very strange and completely implausible. For example, the patient may believe that aliens have removed his brain or heart.

ii) Non-bizarre Delusion: A delusion that, though false, is at least possible. For example, the patient may believe that he is under constant police surveillance.

iii) Mood-congruent Delusion: Any delusion with content consistent with either a depressive or manic state. For example, the patient with depression may believe that news anchors on television highly disapprove of him.

iv) Mood-incongruent Delusion: A delusion that does not relate to the sufferer's emotional state; for example, a belief that an extra limb is growing out of the back of one's head is incongruent to either depression or mania.

v) Simple Delusion: Contains relatively few elements.

vi) Complex Delusion: Contains extensive elaboration of people, spirits, motives and situation.

vii) Systematised Delusion: Systematised delusions are restricted to well delineate areas and associated with clear sensorium.

viii) Non-systematised Delusion: Delusions that are extended up to many aspects of life, new data, people and situation.

ix) Complete Delusion: Complete delusions are held utterly without any doubt.

x) Partial Delusion: In partial delusion, the patient entertains doubt about the delusional idea or belief.

xi) Primary Delusion: Primary delusions are those that are not understandable in terms of patient's culture or mood also called autochthonous delusion. It occurs in an instant without identifiable preceding event.

xii) Secondary Delusion: Secondary delusions are those that are atleast understandable in terms of the patient's culture or mood.

Jaspers originally made a distinction between primary and secondary delusions. Let us understand the difference through explanations in the following manner:

1. PRIMARY DELUSION:

According to Karl Jaspers, primary delusions (sometimes called true delusions) are distinguished by a transformation of meaning, so that the world or aspects of it are interpreted in a radically different way by the delusional person. To others, this interpretation is 'un-understandable' in terms of the normal mental causality, mood, environmental influences and other psychological or psychopathological factors. Jaspers describes four types of primary delusion:

a) Delusional Intuition - where delusions arrive 'out of the blue', without external cause.

b) Delusional Perception - where a normal percept is interpreted with delusional meaning. For example, a person sees a red car and knows that this means their food is being poisoned by the police.

c) Delusional Atmosphere - where the world seems subtly altered, uncanny, portentous or sinister. This resolves into a delusion, usually in a revelatory fashion, which seems to explain the unusual feeling of anticipation.

d) Delusional Memory - where a delusional belief is based upon the recall of memory or false memory for a past experience. For example, a man recalls seeing a woman laughing at the bus stop several weeks ago and now realises that this person was laughing because the man has animals living inside him.

2. SECONDARY DELUSIONS:

Secondary delusions (sometimes called delusion-like ideas) are considered to be, at least in principle, understandable in the context of a person's life history, personality, mood state or presence of other psychopathology. For example, a person becomes depressed, suffers very low mood and self-esteem, and subsequently believes they are responsible for some terrible crime which they did not commit.

Delusions often manifest according to a consistent theme. Although delusions can have any theme, certain themes are more common. Some of the more common delusion themes are:

a) Delusion of Control:

This is a false belief that another person, group of people, or external force controls one's general thoughts, feelings, impulses, or behaviour.

b) Nihilistic Delusion or Cotard Delusion:

This is a false belief that one does not exist, has died or has lost a body organ. It was first described by Dr. Jules Cotard, a French neurologist, in 1880.

c) Delusional Jealousy:

A person with this delusion falsely believes that a spouse or lover is having an affair, with no proof to back up their claim.

d) Delusion of Guilt or Sin (or delusion of self-accusation):

This is an ungrounded feeling of remorse or guilt of delusional intensity. For example, the patient may believe that he has done something wrong for which he has to undergo the punishment.

e) Delusion of Mind being Read:

It refers to the false belief that other people can know one's thoughts. This is different from thought broadcasting in that the person doesn't believe that his or her thoughts are heard aloud.

f) Delusion of Thought Insertion:

It refers to the belief that another thinks through the mind of the person. The person may sometimes be unable to distinguish between their own thoughts and those inserted into their minds. A person with this delusional belief is found to be convinced of their beliefs and unwilling to accept such diagnosis.

g) Delusion of Reference:

Here, the person falsely believes that insignificant remarks, events or objects in one's environment have personal meaning or significance. For example, a person with schizophrenia might believe a billboard or a celebrity is sending a message meant specifically for them.

h) Erotomania:

It refers to a delusion in which a person falsely believes that a particular individual, usually a celebrity or someone of a higher status is in love with him/her. Such a person usually attempts to contact the other person through phone calls, letters or gifts.

i) Religious Delusion:

A religious delusion is any delusion involving religious or spiritual themes or subject matter. For example, a person may believe that he is a god, or given the authority to act as a god.

j) Somatic Delusion:

It refers to a delusion whose content pertains to bodily functioning, bodily sensations, or physical appearance. Usually the false belief is that the body is somehow diseased, abnormal, or changed. A specific example of this delusion is delusional parasitosis: a delusion in which one feels infested with insects, bacteria, mites, spiders, lice, fleas, worms or other organisms.

k) Delusion of Poverty:

Here, the person strongly believes that he is financially incapacitated. This type of delusion is less common now.

l) Delusion of Persecution:

Here, the patient believes that others — often a vague "they" — are out to get him or her. These persecutory delusions often involve bizarre ideas and plots. For example, one believes that Russians are trying to poison him with radioactive particles delivered through his tap water.

m) Delusion of Grandeur:

It refers to the belief that one is a famous or important figure, such as William Shakespeare or Abraham Lincoln. Alternately, delusions of grandeur may involve the belief that one has unusual powers that no one else has e.g. the ability to fly.

n) Delusion of Infidelity:

Here, the patient holds a strong delusional belief that their spouse or sexual partner is being unfaithful to him or her without having any significant proof to back up their claim.

o) Delusion of Recognition:

This refers to the belief that an event or incident that is being experienced currently has already been experienced in the past. Neppe (1983) described 20 different types of such experiences in his book titled *The Psychology of Déjà Vu*. Some of these have specific names:

- déjà vécu already lived through or experienced
- déjà senti already felt
- déjà visite already visited
- déjà entendu already heard

- déjà éprouvé already tried or attempted
- déjà fait already done or accomplished
- déjà pensé already thought or pondered
- déjà raconté already recounted or told
- déjà su already known (intellectually)
- déjà trouvé already met
- déjà voulu already wanted"

o) Delusional Misidentification Syndrome:

Delusional misidentification syndrome is an umbrella term, introduced by Christodoulou (1986) for a group of delusional disorders that occur in the context of mental or neurological illness. They all involve a belief that the identity of a person, object or place has somehow changed or has been altered. As these delusions typically only concern one particular topic they also fall under the category called monothematic delusions.

This syndrome is usually considered to include four main variants:

i. The Capgras Delusion: It is the belief that (usually) a close relative or spouse has been replaced by an identical-looking impostor.

ii. The Fregoli Delusion: It is the belief that various people the believer meets are actually the same person in disguise.

iii. Intermetamorphosis: It is the belief that people in the environment swap identities with each other whilst maintaining the same appearance.

iv. Subjective Doubles: Subjective doubles is the belief that there is a doppelgänger or double of him or herself carrying out independent actions.

However, similar delusional beliefs, often singularly or more rarely reported, are sometimes also considered to be part of the delusional misidentification syndrome. For example:

i. Mirrored-self Misidentification: It is the belief that one's reflection in a mirror is some other person.

ii. Reduplicative Paramnesia: It is the belief that a familiar person, place, object or body part has been duplicated. For example, a person may believe that they are in fact not in the hospital to which they were admitted, but an identical-looking hospital in a different part of the country, despite this being obviously false.

iii. Syndrome of Delusional Companions: It is the belief that objects (such as soft toys) are sentient beings.

iv. Clonal Pluralization of the Self: It is where a person believes there are multiple copies of him or herself, identical both physically and psychologically but physically separate and distinct.

There is considerable evidence that disorders such as the Capgras or Fregoli syndromes are associated with disorders of face perception and recognition. However, it has been suggested that all misidentification problems may exist on a continuum of anomalies of familiarity, from déjà vu at one end to the formation of delusional beliefs at the other.

IV. DISORDER OF FORM OF THOUGHT:

Disorder of form of thought is also called formal thought disorder. This is disorder of conceptual or abstract thinking. Disorders of the form of thought is usually recognised from speech and writing but is sometimes evident from the patient's behaviour e.g., he may be unable to file papers under appropriate category headings.

The form of thought is largely assessed by examining the speech of the patient. Thought is also reflected in behaviour but behaviour is also dependent on factors like personality, motivation and other cognitive processes like memory and orientation. Formal thought disorder typically refers to marked abnormality in the form and flow of thought.

Disorders of form of thought can be divided into three main kinds as under:

- Loosening of Associations
- Derailment
- Neologisms
- Desultory Thoughts
- Drivelling
- Omission
- Clang Associations
- Word salad

These can be described in the following manner:

1. LOOSENING OF ASSOCIATIONS:

This denotes a loss of the normal structure of thinking. To the interviewer, the patient's discourse seems muddled, illogical or tangential to the matter in hand. It does not become clearer when the patient is questioned further, indeed the interviewer has the experience that the more he tries to clearly the patient's thinking, the less he understands it. Several specific features of this muddled thinking have been described, but they are difficult to identify with certainty and the most striking clinical impression is often a general lack of clarity.

2. DERAILMENT:

It is characterized by a speech consisting of a sequence of unrelated or only remotely related ideas. In a mild manifestation, this thought disorder is characterized by slippage of ideas further and further from the point of a discussion. For example, "Some people just don't understand why I had breakfast in America during the world war.

3. NEOLOGISMS:

A neologism refers to a newly coined term, word, or phrase created by combining different words or by breaking them. The use of neologisms is common in children, but is considered indicative of a thought disorder when present in adults. For example, the patient says, "The world is not *gooder* for people like me!" combining two words: "GOOD and BETTER".

4. DESULTORY THOUGHTS:

Here, the speech is grammatically correct however, sudden unrelated ideas force their way in from time to time. The unconscious part of one's mind may be forcing the patient to include other information in his conscious speech. For example, the patient says "My actual problem is that the people never understand me and my stomach feels like an empty bucket" by which he actually means that he is hungry.

5. DRIVELLING:

This refers to mixing of thoughts which makes comprehension difficult. Here, the listener initially feels that the patient has a good idea about what he is going to say further but then he suddenly loses preliminary organization of the thought so that all the constituents get muddled together. For example, the patient says, "Yes, actually that person created all the trouble in my life, … the weather is getting colder day by day".

6. OMISSION:

It refers to the exclusion of some relevant information by the patient while verbally responding to a query. Sometimes, an omitted portion of information may be highly suggestive of the cause of the problems faced by the patient. For example, while giving a detailed account of his family members, the patient may consciously or unconsciously skip the information.

7. CLANG ASSOCIATIONS:

Clang associations refer to a mode of speech characterized by association of words based upon sound or tunes of the words rather than concepts or meanings. This is associated with the irregular thinking apparent in psychotic disorders like schizophrenia. For example, the patient says, "I heard the bell, well, hell, then I fell."

8. WORD SALAD:

Word salad is a confused or unintelligible mixture of seemingly random words and phrases. The words may or may not be grammatically correct, but semantically confused to the point that the listener cannot extract any meaning from them. For example, the patient says, "Tree bus rain food home car tiger".

CONCLUSION:

In this study, the authors have tried their best to provide a detailed view of the disorders of thought by categorising and classifying the different types and subtypes of these disorders. However, keeping the vast scope of the area under study in mind, the authors wholeheartedly accept that there may be many more types of thought disorders that may have skipped the required attention. Therefore, further study is warranted so that more light will be thrown on the dark corners of this area. Let us conclude with some words of wisdom by Allan Lokos, he rightly says, "Don't believe everything you think….."

REFERENCES:

1. Ahmad, A. (2012). Exploring the relationship between Spiritual Personality and Emotional Empathy among Medical and Unani Students. (Unpublished Dissertation). Aligarh Muslim University, India: AL.

2. Casey, P., & Kelley, B. (2007). Fish's Clinical Psychopathology: Signs and symptoms in Psychiatry (3rd Edu.). Jaypee brothers Medical Publishers (P) Ltd. India: New Delhi.

3. Christodoulou, G.N. (1986). The Delusional misidentification syndromes. Basel;Munchen; Paris : Karger.

4. Fish, F. J., Patricia R. C. & Kelly, B. (2007). Fish's Clinical Psychopathology: Signs and Symptoms in Psychiatry. London : The Royal College of Psychiatrists.

5. Fish, F.J., & Hamilton, M. (1994). Fish's Clinical Psychopathology, Bombay: Varghese Publishing House.

6. Jaspers, K. (2008). Allgemeine Psychopathologie. Ein Leitfaden für Studierende, Arzte und Psychologen. Berlin: J. Springer.

7. Lishman, W.A. (1998). Organic psychiatry: The Psychological consequences of cerebral Disorder (3rd Edu). Oxford: Black Well Science.

8. Neppe, V.M. (1983). The psychology of déjà vu: have I been here before?. Witwatersrand University Press: the University of Michigan.

9. Obsessive Compulsive Disorder (2014) American Psychiatric Association. Retrieved from http://www.psychiatry.org/obsessive-compulsive-disorder on 14/9/2014

10. The Phobia List (1995). Retrieved from http://www.phobialist.com on 17/9/2014.

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00231V2I12014
http://www.ijip.in | Oct to Dec 2014

Factors related to Caregiver Burden in Caregivers of Patients with Parkinson's disease in Mumbai, India.

Jagruti Wandrekar*, Nicole D'Souza**, Dr. Maria Barretto***

ABSTRACT:

This study examined the relationship of caregiver burden with various patient and caregiver variables. 50 individuals with Parkinson's Disease were administered the Movement Disorder Society's Unified Parkinson's Disease Rating Scale (MDS-UPDRS), Hoehn and Yahr's Scale (HY), Mini Mental Status examination (MMSE), and their caregivers were administered the Zarit Burden Interview (ZBI). Kruskal Wallis ANOVAs and Mann Whitney U tests showed that caregivers suffering from ill health (U_x=402, p= 0.03) and the patients' MDS-UPDRS scores significantly affected caregiver burden. Simultaneous multiple regression analysis showed that MDS-UPDRS Part I,II and III were significant predictors of burden ($R^{2=}$ 0.72, p<0.0001) of which the motor examination emerged as the most significant predictor of burden.

Keywords: *Care giving, elderly, Parkinsonism*

INTRODUCTION

Parkinson's disease (PD) is primarily a slowly progressive neurological disorder. People with PD experience both motor and non-motor symptoms that have a significant impact on their ability to carry out activities of daily living and which result in a progressive dependence on others to help them with various activities. While caregivers' responsibilities depend on the individual needs of the patient, often in the case of chronic and progressive diseases such as Parkinson's Disease, their responsibilities may keep increasing till at a certain point, caregiving may become their main or only activity (Martinez-Martin et al, 2007). A stable main caregiver has been defined by Martinez-Martin et al as "any person who, without being a professional or belonging to a social support network, usually lives with the patient and, in some way, is directly implicated in the patient's care or is directly affected by the patient's health problem" (Martinez-Martin et al, 2007).

*Consulting psychologist, Parkinson's Disease and Movement Disorder Society, Mumbai, India

**Neurophysiotherapist, Parkinson's Disease and Movement Disorder Society, Mumbai, India

***Psychologist and CEO, Parkinson's Disease and Movement Disorder Society, Mumbai, India

© 2014 J Wandrekar, N D'Souza, M Barretto; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

The focus in this study is on informal caregivers, i.e. caregivers who are not compensated financially for their services and who are most often family members or friends (Vitaliano et al, 2003).

Although some studies have found that caregiving has positive aspects (e.g. Payne, 2001, cited MacRae, Fazio & Russell, 2009), caregiving has largely been studied with respect to the negative impact of the same (e.g.s. Aarsland, 1996, Schrag, 2009, cited MacRae et al, 2009). Caregivers may experience caregiver burden, which is “a multidimensional response to the negative appraisal and perceived stress resulting from taking care of an ill individual” and refers to “the realm of physical, mental, and socio-economic problems experienced by the caregivers of chronic patients” (Zarit et al, 1980, cited Martinez-Martin et al, 2007). It has been found that caregivers of PD patients experience high subjective and objective burden, comparable to that experienced by caregivers of patients having experienced stroke and higher than that in general chronic disease. (Choi &Eun, 2000, cited Kim et al, 2007).

Caregiver burden is important to study as it has a significant impact on various aspects of the physical, psychological, emotional and functional health of caregivers (e.g.sZarit et al, 1980, Parks &Novielli 2000, Etters et al, 2008, Carretero et al. 2009, all cited Martinez-Martin et al, 2007). In addition, caregiver burden has been found to be related to patients’ depression, quality of life, and incidence of falls (Schrag et al, 2006, cited Kim et al, 2007) and caregiver well-being in general has been found to have an impact on the course of the patient’s disease and to determine the use of institutional placement (Dunkin & Anderson-Hanley, 1998, cited Kim et al, 2007).

Accounts of research on caregiver burden and protective and contributive factors among caregivers of patients with Parkinson’s Disease in India are limited (Agrawal et al, 2012). In the current study, caregiver burden was studied in 50 caregivers of patients diagnosed with Parkinson’s Disease, residing in Mumbai, India. The aim of the study was to understand the role of various patient and caregiver variables on caregivers' perceived caregiving burden.

METHOD

Sample

The sample was a convenience sample, with patients and caregivers recruited from among those attending the Parkinson’s Disease and Movement Disorder Society’s Support Centers that are situated throughout Mumbai. The sample consisted of 50 patients diagnosed with Parkinson’s Disease based on the UK Parkinson’s Disease Society Brain Bank criteria (Hughes, 1992) and their primary informal caregivers. Patients who had undergone Deep Brain Stimulation and those with Hoehn and Yahr (HY) stage 5 PD were excluded.

Procedure

Patients and their caregivers were informed about the study and gave their consent for participation. The assessment was conducted by a team of physiotherapists and clinical psychologists over the period of one year (August 2012 to July 2013). All ethical criteria were followed.

Patients were interviewed and demographic details related to their age, gender and duration of illness was noted. The severity of the patients' motor and non-motor symptoms were assessed using the Movement Disorder Society's Unified Parkinson's Disease rating Scale (Goetz et al, MDS UPDRS, Movement Disorder Society, 2008). Staging of the patients' disease was assessed using the Hoehn and Yahr's Scale (HY, Yahr&Hoehn, 1967) and the patients' cognitive functioning was assessed using the Mini Mental Status examination (MMSE, Folstein et al, 1975). Caregivers were also administered a brief questionnaire that assessed demographic variables such as their age, employment status, gender, relationship with the patient, number of caregivers available, family structure and the presence of ill health. Caregiver burden was assessed by administering the caregivers the revised version of the Zarit Burden Interview (ZBI, Zarit, Reever& Bach-Peterson, 1980).

Data Analyses

Data analyses were conducted using online software by Lowry et al (assessed 2013). Descriptive statistics were used for analysing the demographic data. Kruskal Wallis ANOVAs and Mann Whitney U tests were used to examine differences in the ZBI scores across various patient and caregiver variables. Non-parametric statistics were chosen because of the small and skewed sample distribution across various groups. Pearson's Product Moment Correlation coefficient was used to understand the relationship between the MDS UPDRS, the MMSE and the ZBI and this was followed by simultaneous multiple linear regression to see the contribution of each to the caregiver burden score.

RESULTS

Tables 1 and 2 depict the characteristics of the sample of patients as well as their caregivers, respectively. *(Insert Table 1 and 2).*Analyses of our data showed that patient age (Kruskal Wallis H= 0.66, p=0.487), stage of illness (Kruskal Wallis H= 6.84, p=0.145) and illness duration (Kruskal Wallis H= 2.2, p=0.699) were not found to be significantly related to ZBI scores. However MDS-UPDRS scores were found to be significantly related. Results of a multiple regression analysis indicated that the 6 predictors explained 73% of the variance (R^2= 0.73, $p<0.01$). Part I-MDS UPDRS scores ($\beta=0.31$, $p<0.05$), part II- MDS UPDRS scores ($\beta=0.23$, $p<0.05$), part III- MDS UPDRS scores ($\beta=0.55$, $p<0.05$) and total MDS UPDRS scores ($\beta=-0.27$, $p<0.05$) significantly predicted burden, but Part IV- MDS UPDRS scores ($\beta=-0.09$, n.s.) and MMSE scores did not ($\beta=-0.01$).

An analysis of the relationship between the various caregiver variables and the ZBI score showed that only ill health (Mann-Whitney U=402, $p<0.05$**)** of the caregivers had a significant relationship to the ZBI score. Other variables as mentioned in Table 2 showed no significant relationship with the ZBI scores.

DISCUSSION

This study aimed to find the factors related to caregiver burden among caregivers of patients with Parkinson’s disease in an urban population in India. Interestingly, the mean score on the ZBI for the sample was 24.24, which is very low, (SD =16.67), and no one in the study reported high burden levels, with the highest score seen being 62 (with the maximum possible score being 88). In collectivistic Asian-Indian cultures, it is a cultural expectation that family members take up the care of other family members (Pillai et al, 2012) In India, offspring have traditionally been accepting the caregiving role as a natural course of life (Pillai et al, 2012) and the same is likely to hold for spouses of people who develop chronic health conditions. Spouses or offspring may see caregiving as a duty and may willingly undertake the same, and this attitude may lead to lower burden, or it could also prevent them from overtly acknowledging and reporting their burden accurately, even if they may be experiencing stress in the caregiving role.

Also, 76% of the caregivers identified were females. While in this case this was the outcome of convenience sampling, it is also likely to be reflective of general trends in the population.Caregiving is traditionally seen as being the responsibility of wives, daughters and daughters-in-law or the females in a family (Ozdilek&Gunal, 2012), which is particularly true in the Indian society. However, caregiver gender was not found to be related to burden in this study, and neither was caregiver age. Most of the caregivers in this study were spouses, and this could also be reflective of the changing nature of the Indian family unit, with elderly couples staying separately from their children. Inconsistent with Kim et al’s findings (2007) but consistent with Shin etal’s findings (2011), spousal and offspring caregivers showed similar levels of burden, as did other family members who took up the caregiving responsibility. As Shin et al had suggested, it may be that the burden is quantitatively similar but qualitatively different for the spouses, offspring and other family members.

Among the socio-demographic caregiver variables, interestingly, whether one is a sole or co-caregiver for the patient was found to be unrelated to caregiver burden, unlike previous research which suggested that the presence of multiple caregivers led to reduced burden (e.g.sAgrawal et al, 2012, Kim et al, 2011, Martinez-Martin et al, 2007). Also, burden levels were similar for caregivers in nuclear as well as joint families. Interviews with caregivers at the PDMDS support centers in Mumbai have brought to light the fact that even in the presence of multiple people available to care for a patient with PD, the primary caregivers are usually uncertain of the capability of other caregivers to care for the patient adequately and thus prefer to do it themselves, and this may nullify the potential benefits of having multiple caregivers.

In our sample since most of the caregivers were spouses of the patients and were elderly themselves (most of them in the 61- 70 age group), it follows that they may be likely to face

health problems of their own, which may interfere with their caregiving duties. This may be why in the current study, caregivers suffering from ill health, (though not as severe as PD), were found to show significantly more burden than those who did not experience any major personal health issues. Thus caregiver intervention programs must focus on educating caregivers about strategies to manage their own health.

Among the patient related variables, results of the multiple linear regression indicate that taken together, the various disease specific variables are significant predictors of caregiver burden. Since PD is a movement disorder characterized mainly by motor difficulties that lead to significant disability, it is natural that motor examination and motor experiences of daily living, which are indicators of symptom severity and functional impairment as a result of the same, were found to be the strongest predictors of burden, a finding that is in keeping with other research(e.g. Happe& Berger, 2002, cited D’Amelio, 2009). Non-motor experiences of daily living were also found to be modest predictors, similar to Carter et al (2008, cited D’Amelio, 2009). Motor complications such as dyskinesias and dystonias were not found to be significant predictors. This is an important finding and highlights the importance of improving patient health to indirectly decrease caregiver burden.

The level of cognitive functioning has previously been found to be a significant predictor of burden (Shin et al, 2012, Thommessen et al, 2002), but this was not found in the current study. This could be because severe cognitive impairment that may take the form of Parkinson’s Disease Dementia typically occurs much later in the course of PD, and none of the patients in the sample had been diagnosed with the same.

Previous research has shown that the stage of the illness (Shin et al, 2012, Razali et al, 2011, D’Amelio et al, 2009) is related to caregiver burden, but no significant difference was seen in the present study. Not including H & Y Stage 5 patients in the present sample, therefore, may have been a limitation of the study. Patients in stage 5 are often home bound and their dependence on caregivers is typically high, and caregivers of these patients may show a different experience of burden than of those in other H & Y stages.

The current study indicates that while the PD patient’s disabilities accounts for most of the caregiver burden, other factors related to the caregiver like their personal health status also plays an important role. Caregiver burden is not related to one specific key factor, but rather, may be the cumulative effect of a host of varied factors that come together. The patterns by which varied factors combine, and the effects that they have on each individual caregiver, may be qualitatively different, thus leading to different and varied experiences of burden among caregivers. Thus, further research can use qualitative models to understand these dynamics, including cultural attitudinal factors that may have led to low overall reported burden levels in this study. The study has implications in designing intervention programs that focus on helping individuals to cultivate protective factors against caregiver burden.

REFERENCES

1. Agrawal, V., Goyal, V., Shukla, G., Behari, M. (2012). Predictors of caregiver burden of Parkinson's Disease in India: experience of a tertiary care centre in India. *Journal of Parkinsonism & Restless Legs Syndrome, 2:* 56-65.
2. D'Amelio, M., Terruso, V., et al. (2009). Predictors of caregiver burden in partners of patients with Parkinson's Disease. *Neurological Sciences, 30:* 171-174.
3. Folstein, M.F., Folstein, S.E., McHugh, P.R. (1975). Mini-mental state: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research, 12:* 189-198.
4. Goetz, C.G., Fahn, S., Martinez- Martin, P., Poewe, W., Sampaio, C., Stebbins, G.T., et al. (2007). Movement Disorder Society- sponsored revision of the Unified Parkinson's Disease Rating Scale (MDS-UPDRS): Process, format and clinimetric testing plan. *Movement Disorders, 22* (1): 41-47.
5. Hoehn MM, Yahr MD. (1967). Parkinsonism: onset, progression and mortality. *Neurology, 17*: 427– 442.
6. Hughes, A.J., Daniel, S.E., Kilford, L., Lees, A.J. (1992). Accuracy of clinicaldiagnosis of idiopathic Parkinson's disease: a clinic-pathologicalstudy of 100 cases. *Journal of Neurology, Neurosurgery & Psychiatry*: 181–184.
7. Kim, H., Chang, M., Rose, K., Kim, S. (2011). Predictors of caregiver burden in caregivers of individuals with dementia. *Journal of Advanced Nursing, 68 (4):* 846-855.
8. Kim, K.S., Kim, B.J., et al (2007). Subjective and objective caregiver burden in Parkinson's Disease. *Journal of Korean Academy of Nursing, 37 (2):* 242-248.
9. Lowry, R. (2013). VassarStats: Website for Statistical Computation. Available from: URL http://faculty.vassar.edu/lowry/VassarStats.html
10. Martinez-martin, P., Forjaz, M.J., et al. (2007). Caregiver burden in Parkinson's Disease. *Movement Disorders, 22 (7).*924-931.
11. McRae, C., Fazio, E., Russell, D. (2009). Predictors of loneliness in caregivers of persons with Parkinson's Disease. *Parkinsonism & Related Disorders, 15 (8):* 554-557.
12. Ozdilek, B., Gunal, D.I. (2012). Motor and non-motor symptoms in Turkish patients with Parkinson's Disease affecting family caregiver burden and quality of life. *The Journalof Neuropsychiatry & Clinical Neuroscience, 24:* 478-83.
13. Pillai, V.K., Levy, E., Gupta, R. (2012). Relationship quality & elder caregiver burden in India. *Journal of Social Intervention- Theory & Practice, 21 (2):* 39-62.
14. Razali, R., Ahmad, F., et al. (2011).Burden of care among caregivers of patients with Parkinson Disease.*Clinical Neurology & Neurosurgery, 113 (8):* 639-643.
15. Shin, H., Lee, J.Y., Youn, J., Kim, J.S., Cho, J.W. (2012). Factors contributing to spousal and offspring caregiver burden in Parkinson's disease. *European Neurology, 67(5):* 292-296.

16. Thommessen, B., Aarsland, D., et al. (2002). The psychosocial burden on spouses of the elderly with stroke, dementia &Parkinson's Disease. *International Journal of Geriatric Psychiatry, 17 (1):* 78-84.
17. Vitaliano, P.P., Zhang, J., Scanlan, J.M. (2003). Is caregiving hazardous to one's physical health? A meta-analysis.*Psychological Bulletin, 129 (6):* 946-972.
18. Zarit, S.H., Reever, K.E., Bach-Peterson, J. (1980). Relatives of the impaired elderly: correlates of feelings of burden. *Gerontologist, 20 (6):* 649-655.

TABLES

Table 1: Descriptive (frequency, percentages and means) of patient variables

Patient Variables	Number n	Percentage %	Mean(±SD)
Patient Age			
<60 years	7	14	
61-70 years	28	56	66.56 (± 6.91) years
>70 years	15	30	
Hoehn&Yahr Stage			
Stage 1	5	10	
Stage 2	10	20	Stage 3(±0.82)
Stage 3	28	56	
Stage 4	7	14	
Illness duration			
< 5 years	4	8	
5 to 8 years	29	58	8.32(±4.72) years
9 to 12 years	9	18	
13 to 15 years	4	8	
>16 years	4	8	
Total MDS UPDRS score	-	-	64.6(±27.03)
MMSE score	-	-	24.82(±4.23)

Table 2: Descriptives (frequency, percentages) of caregiver variables

Caregiver Variables	Number n	Percentage %
Caregiver Age		
< 40 years	9	18
41-50 years	3	6
51-60 years	10	20
61-70 years	23	46
> 71 years	5	10
Caregiver Sex		
Male	12	24
Female	38	76
Relationship to the patient		
Spouse	38	76
Children	6	12
Others	6	12
Employment Status		
Currently under formal employment	13	26
Non-formal employment (retired/housework)	37	84
Number of caregivers		
Sole	29	58
Multiple	21	42
Personal disability		
Present	22	44
Absent	28	56
Family Structure		
Nuclear	40	80
Joint	10	20

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00232V2I12014
http://www.ijip.in | Oct to Dec 2014

A Study of Academic Stress and Adjustment among Gujarati and English Medium School Students

Dr. K. B. Chothani*

ABSTRACT:

The basic aim of present investigation is that to study the influence of role of medium in the development of child's personality by academic stress and adjustment scales. Present study was undertaken to examine the level of academic stress and adjustment among Gujarati medium and English Medium School Students. For that purpose 120 students of class IX and X were selected randomly from different schools out of which 60 were taken from Gujarati medium school and the remaining 60 were taken from English Medium School. Abha Rani Bisht (BBS) scale for measuring academic stress was used to see the level of stress and Sinha and Singh Adjustment Inventory for school students was used to examine level of adjustment among the students. The data were analyzed by 't' test and ANOVA were applied to check the difference in significance between the entire two mediums of instruction. The main and internal effect has been discussed. Results indicated that level of academic stress was significantly higher among the English Medium school students where as Gujarati medium school students were significantly better in terms of their level of adjustment. The Medium of Mother tongue per both boys and girls adjustment level are high and academic stress level low than other medium of instruction at school level.

Keywords: *Academic Stress, Adjustment, Gujarati and English Medium School Students*

INTRODUCTION

Language is an important factor in an interpersonal relationship. (Ganguly 1996) Language is viewed to be an instrument for social interaction it engaged people in the net work of an activity which yields data for social scientists to study the contours of social conduct of the individual to speak it. Knowingly or unknowingly we all are having a grip of western culture. The western culture can also be seen in our education system. Most of the school students are having their education in that language on which they have a very loose grip. As a result students are mugging the concepts of his subject in place of understanding the same. On the other side student who is having education in his mother tongue or local language will understand the concept in a better way.

*Associate Professor, Dept. of Psychology, C. U. Shah Arts College, Ahmedabad.

© 2014 K Chothani; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

Stress and anxiety in children and teenagers are just as prevalent as in adults. Negligence of parents, high expectations in academic or other performances, abused childhood, growing up tensions and demand for familial responsibility etc. the main causes of childhood and teen stress. Parents, who are not emotionally available for their children or lack positive coping mechanisms themselves, often spur stress in their offspring.

Stressed children show signs of emotional disabilities, aggressive behavior, shyness, social phobia and often lack interest in otherwise enjoyable activities. In a study Dawood (1995) found that students stress affects their academic performance. He further showed that the most frequently mentioned stressor by students was school and fear related stressors. Many teenagers tend to become non conformist and fall prey to teenage depression in response to a variety of growing up anxieties. However, stress induced fears and anxiety in children adversely affects children's performances at various levels. Hodge (1996) investigated that prevalence of stress were found particularly among those students who were by their nature prone to anxiety.

Tung and Chahal (2005) examined relationship between stress and adjustment and found no significical causal relationship between stress and the adjustment . However direction of the results implied that level of adjustment influences the number of stress full events and amount of stress experienced by them.

Adjustment refers to the process of accommodating oneself to circumstances, and more particularly to the satisfaction of needs or motives under various circumstances. An environment barrier may frustrate a person attracted to a positive goal. Then he has to make adjustments with that barrier person who overcomes that particular barrier have good adjustment. We all use defence mechanisms to protect ourselves against anxiety and fear, and certain ones are more used by some people that others. Each day we faced with new situations that demands decisions involve change in both our internal state and our external environment. According to Aggrawal (2004) the adjustment of adolescent very much depends on the fulfillment of their significant specific needs that consist of physical needs, emotional needs, social needs, intellectual needs, moral needs and vocational needs. It may be helpful, therefore, to devote a little more space to two important qualities of adjustment. First, it is a process that involves continuous changes and the second people develop consistent pattern of adjustment to these constant changes. Students make many transitions during their years of schooling: from home to school, middle to high school, and high school to college or work. These transitions are usually major events in the lives of students and parents. The stresses created by these transitions can be minimized when the new environment is responsive to each particular age group. This digest presents a brief overview of some of the issues involved in the transition from elementary to middle school and provide suggestions for transition programs and activities. There are two separate studies G.S.Gupta (1982) N.C.P.Sinha and M.Sharma (1978) in which the correlation between Adjustments was studied, but no consistent relationship was reported. Bhagia (1966) studied found that the girls exceed boys significantly in their adjustment to general environment and organizational aspect of the school.

The basic aim of present investigation is that to study the influence of role of medium in the development of child's personality. Keeping in view the growing problem of academic stress among school students the study was undertaken to examine the level of academic stress among Guajarati and English medium school students and its probable impact on the overall adjustment among them.

HYPOTHESES:

The hypotheses are as follows:

1. Level of academic stress among English medium school students will be significantly higher than the Gujarati medium school students of both sexes.

2. Adjustment level of English medium school students will be significantly different from Gujarati medium school students of both sexes.

The rational for above hypothesis was based on assumption that the performance of school students was generally depended on mastery of language. The school students, who had good command and control over his language, could render the things in an adequate way.

METHOD

Variables

The variable of the present study were as under.

No.	Name of the Variable	Nature of Variable	Number of Level	Name of the Levels
1	Sex	Independent Variable	2	School Boys, School Girls
2	Medium of Instruction	Independent Variable	2	English and Gujarati
3	Academic Stress	Dependent Variable	1	Score of Academic Stress scale
4	School Adjustment	Dependent Variable	1	Score of School Adjustment inventories

RESEARCH DESIGN

2x2 factorial design is used for present investigation as follows.

FACTORIAL DESIGN (2 X 2) = 120 SUBJECTS

Medium of instruction (B)	Sex (A)	
	School Boys (A1)	School Girls (A2)
ENGLISH (B1)	30	30
GUJARATI (B2)	30	30

Sample

Altogether 120 class IX and X students were randomly selected from different types of schools of Ahmedabad. Out of 120 students, 60 were taken from gujarati medium school and the remaining 60 were taken from English medium school of both sex.

Tools

For assessing academic stress of students a 80 items composite scale for assessing academic stress among students consisting of force choice type answer was used choice and higher score indicating academic stress. The scale was developed by Abha Rani Bist, (1987) Similarly, for examining the level of adjustment of the subjects, a 60 items scale developed by Sinha and Singh (1971) was administered on the sample. The scale consist of items in three different areas namely emotional, social and educational with 20 items each. The answer is forced choice and higher score indicating poor adjustment.

RESULTS AND DISCUSSION:

Table-1: Mean, SD and t value of academic stress scores of students of Gujarati medium school (n = 60) and English Medium school (n = 60).

GROUP	ACADEMIC STRESS			't'
	N	M	SD	

ENGLISH MEDIUM SCHOOL	60	63.37	6.50	8.12**
GUJARATI MEDIUM SCHOOL	60	52.97	7.49	

****Significant at .01 levels. (2.62)**

From the results given in table 1, it appeared that magnitude of academic stress among high school students was found to be high particularly among the English medium school students as the mean scores were 63.37 and 52.97 respectively for English medium school and Gujarati medium school students. The difference in terms of academic stress between the two groups of students was also statistically tested by computing t ratio which was also found significant (t=8.12). Thus it can be said that Medium of Istruction, academic load and school environment of English medium school might be contributing towards enhancement of stress among students. Similar results were also obtained by Bohannon (2000). Hence it can be safely said that English Medium school students suffer from higher level of stress related to their academics. Thus hypothesis presuming higher level of academic stress among English medium school students of both sexes was found to be proved.

Table-2: Mean, SD and t value of Adjustment scores of students of Gujarati medium school (n = 60) and English Medium school (n = 60).

Group	**TOTAL ADJUSTMENT**			**'t'**
	N	**M**	**SD**	
ENGLISH MEDIUM SCHOOL	60	22.47	4.96	8.21**
GUJARATI MEDIUM SCHOOL	60	15.98	3.59	

****Significant at .01 levels. (2.62)**

Results given in table II, Indicating the level of overall adjustment among school students revealed that overall adjustment of English medium school students was more poor than the Gujarati medium school students as the mean scores for adjustment were found to be 22.47 and 15.98 respectively for the English and Gujarati medium school students. The difference between the two groups of students with regard to their level of adjustment was also statistically tested and found significant (t=8.21). Isakson (1999) have also found that adolescents experienced significant changes during the initial transition into high school that were related to sense of school membership etc. was also related to adolescents' adjustment to the transition. Hence

adjustment among English medium school students was found to be poor probably because they suffer from high level of academic stress. Thus hypothesis of significant difference between the two groups of students with regard to their level of adjustment was also found to be proved.

Table N0.3: Showing Results of Analysis of Variance on Academic Stress in relation to Sex and Medium of instruction.

Source of Variance	Sum of Square	df	Mean Sum of Square	F	Sign.
A (Sex)	1140.833	1	1140.833	28.483*	.01
B (Medium of Instruction)	3244.800	1	3244.800	81.012*	.01
A x B (Sex x Medium of Instruction)	20.833	1	20.833	0.520	NS
Error	4666.200	116	40.053		
Total	9052.667	119			

***Significant at .01 levels = 3.91**

As per Table No.3, an attempt is made to find out the difference between boys and girls on Academic Stress with the ANOVA Test. The F – ratio of sex is 28.483 which are significant. It means boys and girls group differ significantly on Academic Stress score. So we can say that sex effects on their Academic Stress.

As regards the medium of instruction variable, the mean score on the two groups, English medium students (M = 63.37) and Gujarati medium students (M = 52.97) and as given in Table No.1 The overall difference was found significant (F = 81.012, sign. at .01) It means Gujarati and English medium school students group differ significantly on Academic Stress score. So we can say that medium of instruction effects on their Academic Stress.

Table No.3, Shows the F – ratio of sex x medium of instruction is 0.520, which is insignificant. It means there is no significant interaction between sex x medium of instruction. Sex x medium of instruction do not effect on Academic Stress.

Table N0.4: Showing Results of Analysis of Variance on Adjustment in relation to Sex and Medium of instruction.

Source of Variance	Sum of Square	df	Mean Sum of Square	F	Sign.
A (Sex)	533.08	1	533.08	37.108*	.01
B (Medium of Instruction)	1261.008	1	1261.008	87.726*	.01
A x B (Sex x Medium of Instruction)	9.075	1	9.075	0.631	NS
Error	1667.433	116	14.377		
Total	3470.925	119			

***Significant at .01 levels 3.91**

As per Table No.4, an attempt is made to find out the difference between boys and girls on Adjustment with the ANOVA Test. The F – ratio of sex is 37.108 which are significant. It means boys and girls group differ significantly on Adjustment score. So we can say that sex effects on their Adjustment.

As regards the medium of instruction variable, the mean score on the two groups, English medium students (M = 22.47) and Gujarati medium students (M = 15.78) and as given in Table No.1 The overall difference was found significant (F = 87.726, sign. at .01) It means Gujarati and English medium school students group differ significantly on total adjustment score. So we can say that medium of instruction effects on their total adjustment.

Table No. 4, Shows the F – ratio of sex x medium of instruction is 0.631, which is insignificant. It means there is no significant interaction between sex x medium of instruction. Sex x medium of instruction do not effect on school Adjustment.

CONCLUSION:

1) There is a significant difference between students of Gujarati medium school and that of English medium school in the area of academic Stress. Students of English medium school are high academic Stress than Gujarati medium school. It means students of English

medium school have higher academic Stress, which state they have an impending fear from the environment in the form of teacher and subject.

2) There is a significant difference between students of Gujarati medium school and that of English medium school in the area of total adjustment. Students of Gujarati medium school well adjusted than the English medium school students.

REFERENCES

1) Abha Rani Bisht (1987). Bisht Battery of Stress (BBSS), National Psychological Corporation, Agra, India.

2) Aggrawal, J.C. (2004). *Psychology of learning and Development*, Shipra Publication, Delhi.

3) Bhagia N.M. (1966) Study of the problem of School Adjustment and development an Adjustment Inventory. Unpublished Ph. D. Thesis, M.S. University, Baroda.

4) Bhargavi Devi (1995) Academic stress and anxiety in elementary school children. An unpublished MSc Dissertation submitted to S V U Tirupati.

5) Bohannon, A.P. (2000). The relationship of School related stressors to discipline Academic Stress and Adjustment referrals, attendance, grade point average and under achievement among high school students. *Dissertation Abstracts International*, 57, 1482.

6) Dawood, N. (1995). Stressors encountered by junior high school students and their relation to grade point average, sex and grade. Jordan, Deanship of Academic Research, 22, 3671-3706.

7) Hodge, Glenda Mae (1996). Adolescent Anxiety, distress and coping: A study of senior school students and higher school certificate examination stress. *Dissertation Abstract International*, *57*, 01 14.

8) Isakson, K. (1999). The adjustment of adolescents during the transition into high school: A short-term longitudinal study. *Journal of Youth and Adolescence*, *28*, 1- 26.

9) Sinha, A.K.P. and Singh, R.P. (1971). *Adjustment Inventory for school students.* National Psychological Corporation, Agra, India.

10) Tung, S. and Chahal, N. (2005). Relationship between Stress and Adjustment Adolescents females; A causal study , *Journal of Personality study and Group Behavior* , Amritsar, 25, 19-31.

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00233V2I12014
http://www.ijip.in | Oct to Dec 2014

A Comparative Study of Adjustment and Achievement Motivation of Normal and Physically Handicapped College Students

Dr. Pradeep Shyam Ranjan *

ABSTRACT:

The study aimed to investigate the difference in adjustment and achievement motivation between normal and physically handicapped college students. The sample consists of 80 college students selected from Lalitpur (U.P.) city. A set of tools containing Adjustment Inventory for College Students (AICS) and Achievement Motive Test (AMT) were administered to gather information. The result revealed that there is significant difference in home, health, social and emotional adjustment of normal and handicapped college students.

Keywords: *Physical handicappedness, Adjustment, Achievement motivation*

INTRODUCTION

Human being is the most precious creation of god. Human being is biological as well as emotional, social, and cognitive. All these aspects play significant role in one's functioning as well as in adjustment in different walks of life. Any deficiency, physical or mental, creates problems in adjustment. Physical handicappedness is one of the major obstacles in adjustment. According to Bala and Rao (2007, p.4) "an individual who is afflicted with a physical impairment that, in any way, limits or inhibits his/her participation in normal activity is called physically handicapped". The physically handicapped person has to adjust with their own disabilities as well as to their social circle. Actually, they have to bear a double-burden, social handicap and actual physical loss. According to Hardwick (1942) "Disabled person is much more exposed to physical and mental strain than the average man. Very often he receives unfavorable attitudes from society. These produce maladjustments in him. The disabled man is like someone running a business with a minimum of capital."

The concept of adjustment was originally a biological one and was corner stone in Darwin's theory of evaluation. Adjustment is a condition or state in which one feels that one's needs have been fulfilled and one's behavior conforms to the requirements of a given culture. Adjustment is, the orderly, systematically and smoothly functioning of things. Because adjustment is a form of behavior, that comes through social interaction, therefore the adjustment, or maladjustment of any individual is directly affected by the social context in which he is living. When the social and psychological needs of the physically handicapped students are not gratified, they may develop adjustment problems.

*Educational Counselor, R.L.P.S. Jhansi (U.P.)

© 2014 P Ranjan; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

They face many problems in his adequate adjustment on account of his physical deformity.

Motives play multiple roles in our life. Our daily activities are all causally determined. Achievement motivation is defined as a desire for attaining some specific standard of excellence. It has great significance in understanding human behavior as well as in changing it. Achievement helps people to overcome their feeling of inferiority.

There has been little research on the physically handicapped college students. Available researches indicate the difference between normal and handicapped students. Cruckshank (1951) evaluated that children with various types of orthopedic, cardic and neurological handicaps see themselves a having more fear and quite than normal children. George, Pillay and Dharmangadan (1967) found in his study that physically defective pupils were inferior in comparison to non-defective counterparts in home, health and school adjustment. The normal college students probably due to better body structure and performance at college and society get more love and affection and shows better adjustment in these areas. Chawla (1978) have find out that normal showed better adjustment in the entire areas-emotional, social, and educational as compared to physically handicapped. Although there are some studies that show that impaired persons are better adjusted in social and emotional areas (Satapathy and Singhal, 2003).

OBJECTIVE OF THE STUDY

The present study is intended to find out the:

1. Difference of adjustment pattern between normal and physically handicapped college students, and
2. Difference of achievement motivation between normal and physically handicapped college students.

METHOD

Sample

This study was conducted on a sample of 80 (40 normal and 40 physically handicapped) college students. The sample was taken from Nehru Degree College Lalitpur (U. P.) and Raghuveer Singh Rajkeeya Mahaviddyalya Lalitpur (U. P.). Subjects were belonged to graduation and post graduation level and their age range was 18-25 years.

Measuring Tools

Following tools were used for measurement of adjustment and achievement motivation:

Adjustment Inventory for College Students (AICS)

Test is prepared by Sinha and Singh (1992) and used for the measurement of adjustment of students. Test contains 102 items related five areas namely home, health, social, emotional and educational. Low scores show satisfactory adjustment.

Achievement Motivation Test (AMT)

This test is constructed by Bhatia (2001) and used for the measurement of achievement motivation. Test included 25 items. The test retest reliability coefficient of test was .82. The empirical validity of test is .88.

RESULT

The collected data were tabulated and analyzed in following tables:

Table-1, Home Adjustment Difference

GROUP	N	M	SD	CR	P
NORMAL	40	3.53	1.73	3.935	.01
HANDICAPPED	40	5.6	2.85		

The statistical analysis of Table-1 reveals that mean score of normal students were lower than handicapped college students. Critical ratio (CR) between two groups is 3.935 and significant at .01 levels. Lower mean of normal students show that they are better adjusted at home than handicapped students.

Table-2, Health Adjustment Difference

GROUP	N	M	SD	CR	P
NORMAL	40	3.15	2.05	4.176	.01
HANICAPPED	40	5.23	2.39		

The statistical analysis of Table-2 reveals that mean score of normal students were lower than handicapped college students. Critical ratio (CR) between two groups is 4.176 and significant at .01 levels. Scores indicated that normal students shows better health adjustment than handicapped students.

Table- 3, Social Adjustment Difference

GROUP	N	M	SD	CR	P
NORMAL	40	7.35	2.77	3.182	.01
HANDICAPPED	40	9.8	4.01		

The statistical analysis of Table-3 reveals that mean score of normal students were lower than handicapped college students. Critical ratio (CR) between two groups is 3.182 and significant at .01 levels. Scores indicates that normal students are more adjusted in society than handicapped students.

Table-4, Emotional Adjustment Difference

GROUP	N	M	SD	CR	P
Normal	40	11.83	4.73	3.861	.01
Handicapped	40	15.88	4.66		

The statistical analysis of Table-4 reveals that mean score of normal students were lower than handicapped college students. Critical ratio (CR) between two groups is 3.861 and significant at .01 levels. Scores shows that normal students are more emotionally adjusted than handicapped students.

Table-5, Educational Adjustment Difference

GROUP	N	M	SD	CR	P
Normal	40	6.15	2.94	1.388	N.S.
Handicapped	40	7.03	2.73		

The statistical analysis of Table-5 reveals that mean score of normal students were lower than handicapped college students. Critical ratio (CR) between two groups is 1.388 that is not significant at any level of significance.

Table-6, Difference of Achievement Motivation

GROUP	N	M	SD	CR	P
Normal	40	32.95	6.56	.319	NS
Handicapped	40	32.38	9.197		

The statistical analysis of Table-6 reveals that mean score of handicapped students were lower than normal college students. Critical ratio (CR) between two groups is .319 and not significant at any levels of significance.

DISCUSSION

Findings of the study are consistent with prior studies. Result shows that normal students are better adjusted in the area of home, health, social, and emotional. Result is supported by the study of George, Pillay and Dharmangadan (1967), Schlesingner and Meadow (1972), and Chawla (1978). The normal college students probably due to better body structure and performance get more love and affection at home, college, and in society. Therefore they show better adjustment in these areas. On the other hand, due to their physical impairment, handicapped students face many types of prejudices and society's unfavorable attitude. These things affect their adjustment in some areas.

Result shows no significant difference in educational adjustment between normal and handicapped college students. Result also shows no significant difference in achievement motivation between normal and handicapped college students. Results indicate that physically handicapped students are equally adjusted in education area as normal students. They also show motivation for achievement. Handicapped people may develop inferiority due to their physical impairment and they motivated for achievement to overcome their inferiority. According to Adler, People are forever struggling to overcome their feelings of inferiority. Acting on this urge, people strive for superiority (Morgan, King, Weisz, and Schopler, 1993).

CONCLUSION

The main findings of the study are:

1. Normal and handicapped college students are differ in four areas of adjustment namely home, health, social, and emotional. Normal students show better adjustment in these areas.
2. There is no significant difference in educational adjustment of normal and handicapped college students.
3. There is no significant difference in achievement motivation of normal and handicapped college students.

REFFERENCE

1. Bala, J. M, and Rao, D. B. (2007). Hearing Impaired Students: Adjustment, Achievement Motivation and Academic Achievement. Discovery Publishing House, New Delhi-110002.
2. Bhatia T. (2001). A. M. T.. Department of Psychology, D.V. College Urai (U.P.)-285001.
3. Chawla, P. (1978). A Comparative Study of Adjustment and Anxiety of Physically Handicapped. *Masters Dissertation in Psychology, Jabalpur University.*
4. Cruickshank, W.M. (1951). The effect of physical disability on personal aspiration. *Quarterly Journal of Child Behavior*, 3, 322-33.
5. George,E.I.,Pillay and Dharmangandan (1967).Effect of Physical Disability on Personality of Secondary School Pupils. *Journal of Education and Psychology.*
6. Hardwick, J.C, (1942). The Conquest of Disability. The Macmillan, Co., Toronto.
7. Morgan, C.T., King, R.A., Weisz J.R., and Schopler J. (1993). Introduction to Psychology. Seventh edition. Tata McGraw-Hill, 7 West Patel Nagar, New Delhi 110008.
8. Satapathy, S. and Singhal, S. (2003). Social- emotional adjustment of hearing impaired and non impaired adolescents: Grades and gender differences. *Journal of Psychological Researches*, 47(1), 1-8.
9. Sinha A.K.P. and Singh R.P. (1992). AICS. National Psychological Corporation 4/230 Kacheri Ghat, Agra, India.

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00234V2I12014
http://www.ijip.in | Oct to Dec 2014

Effect of Anasakti and Level of Post on Job Satisfaction of Employees

Pushpendra Rao Upadhyay*, Dr. A.C. Vashishtha**

ABSTRACT:

The present study aims to study the effect of anasakti and level of post on job satisfaction of employees. The study was guided by the hypothesis that there will be no significant effect of anasakti and level of post on job satisfaction of employees. For this purpose sample was consisted of 120 employees were selected through quota random sampling. The data were collected through standardized tools from each subject individually. A 2X3 factorial design was employed to find out the effect of anasakti and level of post on job satisfaction. The obtained raw data were analyzed by Mean, SD, Newman-Kules and Analysis of variance (ANOVA).The results indicated that the anasakti and level of post was significantly affect the job satisfaction of employees.

Keywords: *Anasakti, level of post, Job satisfaction, Employees.*

INTRODUCTION

Asakti and Anasaktiboth are the Sanskrit term recognized as Bi-dimensional personality types in Indian psychology like the trait attachment and non-attachment in western psychology. (Bhusan, 1994) define Asakti (attachment) and Anasakti (non-attachment) as a Bi-polar of the same personality dimension.Banth and Talwar (2006, 2011) suggested that anasakti Sanskrit term for traits like non-attachment, equipoise, selfless duty orientation and efforts in the absence of concern for the outcome, can be regarded as a Hindu-ideal cluster of personality traits. Everyone possesses a certain degree of attachment and non-attachment but no one hundred percent "attached" or hundred percent "detached". Like any Bi-polar personality characteristics individual differ in its magnitude. Some are high in attachment (low in detachment) while others may be high in detachment (low in attachment). In most others cases we find a mixture of the two manifested in ambivalent behaviour (Bhushan, 1994). Taking Asakti (attachment) and (Anasakti) detachment as the two extreme points on a continuum, we can define the construct operationally and identify who is an attached or detached person. Attachment-detachment manifests in a variety of thinking, feeling and action patterns. This would be based on the description given in the Bhagavad Gita.

*Research Scholar, Dept. of Psychology Meerut College, Meerut.
**Professor, Dept. of Psychology, Meerut College, Meerut.

© 2014 A Vashishtha, P Upadhyay; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

In generic sense Asakti means attraction towards any individual or object to gain its fruits or result and Anasakti is opposite to the Asakti. Asakti (Attachment) arouses the idea of possession, the sense of ownership. It gives rise to dependence on attachment to objects for deriving some excitement and pleasure. Naturally a person high in attachment becomes a victim of his expectations and their fulfilment, circumstances and events. He cannot escape the torments of victory and defeat. Like a pendulum he swings from elation to sorrow. Anasakti (nonattachment), on the other hand, develops internal freedom. "It frees you from the fetters which bind you to the ordinary plane of awareness. A man who is anasakt may enjoy the pleasures of life, acquire wealth and status, raise a family that he loves, and control a vast business or even an empire. However, he is never dependent on them. He enjoys everything but as the master and not the slave. He develops an inner freedom or independence and remains unaffected by success and failure. Detachment, therefore, is an ability to remain unaffected in the face of the trials and tribulations of life (Saraswati, 1984). Anasakti does not mean a negation of love. On the other hand, it is actually an extension of the limited relationship of love without an expectation. A person who is really detached loves all without discrimination, without considering who is his near relation, friend or enemy. He loves all without involvement and expectation. The love of a detached (Anasakt) person creates a supremacy of benevolence in his character. In Indian psychology, the term moha which literally means 'narrowing the area of consciousness' is used as a synonym for asakti. So, the higher one is in attachment, the narrower the area of intimacies, relationships and so-called love. On the other hand, the higher one is in detachment, the greater the area of oneness and love.

Pande and Naidu (1992) explained that anasakti involves acceptance of life circumstances without attachment to them, along with committed action (anasakt action), without expectations of rewards or results. The authors stated that anasakt action does not mean refraining from physical activity, but involves intense and impartial action while not being focused on evaluation or desire for success or gain. The authors further explained that anasakt action thus involves an individual becoming one with his or her actions, minimizing energy expenditure, which allows for more energy to focus on producing increased quality and a productivity among most daily tasks.

Anasakti (Nonattachment) also has similarities to the Buddhist concept of equanimity, a balanced mind state where mental reactions are observed while the mind remains peaceful. Equanimity, as explained by Hanson (2009), involves observing the content passing through the mind, as it "breaks the chain of suffering by separating the feeling tones of experience from the machinery of craving, neutralizing your reactions to those feeling tones" (p. 109). The author indicated that this de-conditioning and non-grasping approach to life can allow the dormant potential of positive emotions and action such as compassion to arise. Eventually, nonattachment and equanimity lead to actions being guided by values and not by habitual craving, avoidance or other reactions to positive or negative internal mental stimuli (Hanson, 2009).

As a construct, **job satisfaction** is extremely complex with no single conceptual model completely and accurately describing the construct (Hagedorn, 2000). Job satisfaction has been defined as "a pleasurable or positive emotional state resulting from the appraisal of one's job or

job experiences" (Locke, 1976, p. 1300). Vroom (1964) defined job satisfaction as the attitude an individual carries about work roles and the corresponding relationship to worker motivation. Variables that influence job satisfaction include promotional opportunities, positions that provide high pay, considerate and participative supervision, opportunities to interact with peers, a variety of duties and a high degree of control over work methods and pace.

Job satisfaction refers to a dedicated evaluation of the job as a whole, but also refers to components such as financial rewards, resources to get the job completed, interest, challenge, use of valued skills, variety, occupational prestige, autonomy, relations to co-workers and supervisors, involvement in decision making, and comfort factors such as hours, physical surroundings and travel time. The essence of job satisfaction is the fit of congruence of the worker and the job (Mortimer, 1979). Job satisfaction is concerned with the attitudes people have about work rather than efforts to fill a need, or the past tense involving outcomes already experienced. Comparatively, motivation suggests the present tense where individuals strive toward an outcome. While different in context, satisfaction and motivation are related and both are used to evaluation of employees. Motivation has been defined as a crucial issue that influences activities of individuals in organizations, which results in job satisfaction (Padde, 1993). Numerous studies have been completed over the years in an attempt to classify, determine and/or predict job satisfaction (Locke, 1976). The studies can be grouped into two approaches: content and process (Buford and Bedeian, 1988). Herzberg (1959), Vroom (1964), Maslow (1970), Locke (1976) and McGinnis (1985) have studied what motivates individuals to behave in a certain way and strive toward a particular behavior. Herzberg's (1959) study distinguished two factors that influenced job satisfaction. Intrinsic factors, or motivators, (i.e., interest in the job, achievement, work and recognition) lead to job satisfaction while extrinsic factors, or hygienes, (i.e., policy and administration, an individual's relationships with peers and supervisors, working conditions, job security and pay) lead to job dissatisfaction. The theory was based on satisfaction whereby employees are motivated from within and are not self-motivated (Herzberg, Mausner and Snyderman, 1959).

A national study of male workers found that job satisfaction was most likely related to ego-related factors such as interest, variety, responsibility and competence (Gurin, Veroff& Feld, 1960). Kohn and Schooler's (1973) study of American workers suggested job satisfaction is closely tied to closeness of supervision, routinization of work and substantive complexity. The significance of autonomy and job scope (Shepard, 1973; Stone, 1976) and opportunities to use one's ideas and skills, learn new things, and set one's own pace of work are additional items leading to job satisfaction (Tannenbaum, Kavic, Rosner, Vianello, &Wieser, 1974). Other studies have focused on degree of formalization, centralization and complexity, decision-making and styles of supervisory personnel in managing conflict (Newman, 1975; Seashore and Taber, 1975; Locke, 1976). Individual differences in worker characteristics have been found to not be ofcrucial importance in generating job satisfaction and dissatisfaction; therefore, the same work features generally contribute to the satisfaction of all workers in the same way with the level of importance the basic variance (Voydanoff, 1978). With work characteristics not of considerable

importance, job satisfaction changes have been found to be related to workers' subjective reactions to their jobs and noted improvements in efforts to enrich and/or enlarge jobs, increased economic benefits and security or enhanced working conditions and relationships (Mortimer, 1979). O'Toole (1973) found workers responding to self-fulfillment in their work through meaningful, enriching, growth-inducing work.

Motivation toward job satisfaction involves the attraction to a job for a variety of reasons before the job is taken. After assuming the position, individuals must be encouraged to put forth enough interest and energy to result in an acceptable effort. Finally, human resources must be developed and maintained to bring about success to the organization (Vroom, 1983). Studies by McGinnis (1985) supported that motivation and job satisfaction by subordinates in relation to supervisors can be enhanced with these suggestions: 1) expect the best from people you lead; 2) establish high, yet realistic, standards for excellence; 3) create an environment where failure is not fatal; 4) recognize and applaud achievement; 5) appeal sparingly to the competitive urge; 6) place a premium on collaboration; and 7) take steps to keep your own motivation high.

The Hierarchy of Needs developed by Maslow (1970) provided a basic foundation for understanding individuals' needs and desires. The theory was established with the premise that certain needs must be met before proceeding to higher levels of desires. Basic needs such as food, clothing and shelter must be met for survival. More complex desires included safety, belonging and love, self-esteem and status and self-actualization. Gruneberg (1979) used Maslow's theory to provide some evidence of job satisfaction of workers. Individuals employed in lower level-type occupations were more likely to be motivated by pay and security. After basic needs were met, higher level-type occupations were more interested in fulfilling higher order needs.

McClelland (1973) developed the Achievement Theory that suggested achievers have three basic qualities: 1) they like situations in which they take personal responsibility for finding solutions to problems, 2) they have a tendency to set moderate achievement goals and to take calculated risks and 3) they want concrete feedback about how well they are doing. Achievement varies per the individual. Therefore, managers can structure work situations to fully use the talents of high need for achievement individuals.

The Goal Setting Theory operates under the premise that a person's goals and intentions regulate a person's behavior. Research studies by Locke (1976) suggested that setting specific goals results in higher productivity. Managers can further enhance employee productivity by providing feedback on goal attainment.

Each of the motivational theories provide suggestions for measuring job satisfaction, but conflict in any of the theories arises when some factors may serve as job satisfaction factors for some and not others. The local administrator has an important role in creating, monitoring and maintaining the expectancies and reward structures that lead to job satisfaction. Administrators need to provide clear goals for subordinates while also being aware and making adequate use of

organizational goals, philosophies and rewards. Administrators must use a contingency approach that is flexible, multifaceted and based on astute diagnosis of the situation (Kast&Rosenzweig, 1985).

METHODOLOGY

Objectives of study:

1. To study the effect of anasakti on job Satisfaction of employees.
2. To study the effect of level of post on job Satisfaction of employees
3. To study the interaction effect between anasakti and level of post on job Satisfaction of employees.

Hypotheses:

Following hypotheses were formulated for empirical verification in connection with the fulfillment of the objectives of the present study.

1. There will be no significant effect of ansakti on job Satisfaction of employees.
2. There will be no significant effect of level of post on job Satisfaction of employees.
3. There will be no significant interaction effect of anasakti and level of post on job Satisfaction of employees.

Design of the study:

A 2x3 groups design was employed in the present research. The first independent variable of the study was ansakti which was consisted of two groups, i.e. high anasakti and low anasakti. The second independent variable of the study was the level of post that was varied at three levels, i.e. high, medium and low level of post. The dependent variable of the study was job satisfaction.

Sample:

In this research sample was consisted of 120male employees of International Automobile Organizations located at Faridabad, Haryana. Subjects with the average age of 26 years were selected through quota-cum random sampling. Out of 600 employees, after the screening through anasakti scale, extreme 60 high as well as extreme60 low respondents were selected in the high and low anasakti groups.Total sample of high and low anasakti groups was further divided into three sub groups (N=20 in each group) i.e. low level of job, medium level of job and high level of job.

Tools:

In the present study following tools were used for the measurement of variables under the study:

Anasakti Scale for Professionals:

A self-developed of anasakti has been used to measure the ansakti of employees working at various levels of post in different automobile industry. This questionnaire originally developed by Dr. Sanjay kumar (CCS University) containing 47 items related to the nature and behavioral orientation to anasakti. After item analysis a total 40 items were remained in the final draft. The construct validity of the scale was found 0.84 and test- retest reliability of the scale was 0.91.

Job Satisfaction:

Job Satisfaction scale (Hindi version) originally constructed by Anukool Hyde, SanjyotPethe and UpindarDhar and published by Vedant publication, Lucknow has been used to measure the job Satisfaction of employees. This scale included 34 items. The split half reliability coefficient was found to be 0.88 and the face validity of the scale was 0.93.

RESULT:

Findings of the present study were presented in Table-1

Table-1: Analysis of Variance of Anasakti and Level of Post.

Sources of Variances	Ss	Df	MS	F
Anasakti (A)	**11960.04**	**1**	**11960.04**	**63.33****
Level of Post (B)	**1220.47**	**2**	**640.53**	**3.39***
Interaction (A X B)	**2081.06**	**2**	**1040.53**	**5.51****
Error	**21528.90**	**114**	**188.85**	
Total	**36790.47**	**119**		

**Significant at 0.01 level of significance.

*Significant at 0.05 level of significance.

A look at the table showing F-ratio of the group of anasakti, i.e, high and low ansakti was found to be [F-120(1,114), 63.3, P<0.01] which was found significant at 0.01 level of significance, it means that anasakti an effective variable in influencing job satisfaction of employees; and the F-ratio of the variable of level of post was found to be [F-120 (2,114), 3.09, P<0.05] indicate that level of post was an effective variable in influencing job satisfaction. Finally the F- ratio of

interaction of anasakti and level of post was found to be [F-120 (2,114), 5.51, P<0.01] which indicated that the interaction between anasakti and level of post was found to be effect on job satisfaction at .01 level of significance.

DISCUSSION:

(Tripathi, Naidu, Thapa& Biswas, 1993) observed that the employees who are low on Asakti (attachment) most often covary with type A personality, scores indicate greater depression, fear, guilt and reported daily hazels comparative to employees high on Anasakti (Non-attachment). Dr. Ira Rosenman (1993) found in their cross-cultural study that Anasakti was associated with lower depression and anxiety, it did not buffer it to a small but significant extent. Thapa (1983) found students high on outcome orientation (Asakti) perceived grater distressed when they encountered stressors and manifested greater syptoms of strain compared to students high on efforts orientation.(Pande& Naidu, 1986, 1992; Naidu &Pande, 1990) found Anasakti was a health promoting attitude; employees high on Anasakti are less to govern by external standards such as social approval or censor. His behavior will guided by correctness of conduct and excellence in performance that they are more satisfied as compared to group. Swami chimmayananda (1975) high anasakt employees show total absorption in the task at hand. He would manifest complete involvement in all kinds of tasks that they may undertake dissolving the past fears and futures expectations.(pande& Naidu, 1990) revels that high Anasakti employees show high concentration on is job work, able to focus on tasks at hand and would not be easily distractible, comfortable on any task with selective ease regardless of what be its affective value for him. This reveals that subjects high on Anasakti have opportunity to develop good personality skill which help them to feel more efficient, social and individually contented for all the responsibilities at work, whereas low on Non-attachment always busy in managing their personal grievances and never feel satisfied so significant difference was observed in results.

REFERENCES:

1. Banth, Sudha; Talwar, Charo (2006). Anasakti, the Hindu ideal and its relationship to well-being and orientation to happiness. Journal of religion and health, DOI: 10.1007/s10943-9402-3.
2. Bhushan, L.I. (1994). A yogic Model of mental health. Indian journal of psychological issues, 2, pp: 1-4.
3. Gurin, G.,Veroff, J. and Feld, S. (1960). Americans view their mental health. New York: Basic Books.
4. Hagedorn, L.S. (2000). Conceptualizing faculty job satisfaction: Components, theories, and outcomes. In Hagedorn, L.S. (Ed.), what contributes to job satisfaction among faculty and staff? San Francisco: Jossey-Bass.
5. Hanson, R. (2009). *Buddha's brain: The natural neuroscience of happiness, love & wisdom*. Oakland, CA: New Harbinger.
6. Herzberg, F. (1959). The motivation to work (2nd ed.), New York: John Wiley & Sons.

7. Herzberg, F., Mausner, B., and Snyderman, B.B. (1959). The motivation to work. New York: John Wiley & Sons.
8. Kohn, M. and Schooler, C. (February, 1973). Occupational experience and psychological functioning: An assessment of reciprocal effects. American Sociological Review, 38, 97-118.
9. Locke, E.A. (1976). The nature and causes of job satisfaction. In Marvin D. Dunnette (Ed.), Handbook of industrial and organizational psychology (p. 1297-1349). Chicago: Rand McNally College Publishing Company.
10. Maslow, A.M. (1970). Motivation and personality. New York: Harper and Row.
11. McGinnis, A.L. (1985). Bringing out the best in people: How to enjoy helping others excel. Minneapolis, MN: Augsburg.
12. Mortimer, J.T. (1979). Highlights of the literature: Changing attitudes toward work. Scarsdale, NY: Work in America Institute, Inc.
13. Newman, J.E. (Dec., 1975). Understanding the organizational structure-job attitude relationship through perceptions of the work environment. Organizational Behavior and Human Performance, 14, 371-397.
14. Padde, P. (1993). An evaluation of the supervisory techniques of the Extension supervisors as they relate to the job performance among the Extension agents in the agricultural Extension service in the eastern region of Uganda. Unpublished masters' theses. Columbus, OH: The Ohio State University.
15. Pande, N., & Naidu, R. K. (1992). Anāsakti and health: A study of nonattachment. *Psychology and Developing Societies, 4*, 89-104. doi:10.1177/097133369200400106
16. Saraswati, Swami Satyananda and Swami Satyasangananda (1984). Karma Sannyasa. Munger: Bihar School of Yoga.
17. Seashore, S.E. and Taber, T.D. (Jan-Feb, 1975). Job satisfaction indicators and their correlates. American Behavioral Scientist, 18, 333-368.
18. Shepard, J.M. (October, 1973). Specialization, autonomy, and job satisfaction. Industrial Relations, 12, 274-281.
19. Tannenbaum, A.S., Kavic, B., Rosner, M, Vianello, M. and Wieser, G. (1974). Hierarchy in organizations. San Francisco: Jossey-Bass.
20. Voydanoff, P. (May, 1978). The relationship between perceived job characteristics and job satisfaction among occupational status groups. Sociology of Work and Occupations, 5, 179-192.
21. Vroom, V.H. (1964). Work and motivation. New York: John Wiley & Sons.

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00235V2I12014
http://www.ijip.in | Oct to Dec 2014

Role of Mindfulness-Based Cognitive Therapy in Alleviating Psychological Distress among Cancer Patients

Fatemeh Abdollahi*, Prof. Mahmood S. Khan**

ABSTRACT:

The purpose of this research was to examine the research literature on role of Mindfulness-Based Cognitive Therapy in alleviating psychological distress among cancer patients. World Health Organization and medical experts have expressed alarm about constantly the growing problem of cancer patients in the world. The researcher emphasize that the diagnosis of cancer not only has obvious physical ramifications for the patient, but also the trauma of a diagnosis produces psychological problem such as somewhat hardly manageable distress as well, and in the face of psychological stressors that negatively impact the patient's overall quality of life. The present study examined the results of various studies, for identifying the potential efficacy of MBCT as it could be applied to patients with cancer which presents psychological distress. Research on Mindfulness-Based Cognitive Therapy has supported the safety and effectiveness of this approach might be used with distress associated problems among cancer patients also other studies obtained results signified the effectiveness of this therapy while dealing with cancer patients showed significant impact in alleviating different type of problems associated with this disease. It suggests need for a comprehensive solution that combines medical, psychological, social and behavioral approach to this complex problem in initiating the distress of cancer patients.

INDIAN PSYCHOLOGY

Keywords: *Mindfulness-Based Cognitive Therapy, Psychological Distress, Cancer*

INTRODUCTION

In 2014, World Health Organization (WHO) examined that the cancer is a devastating disease for millions of people around the world. The incidence of cancer is steadily increasing and approximately 8.2 million people worldwide died from cancer in 2012, 60% of world's total new annual cases occur in Africa, Asia and Central and South America, 30% of cancers could be prevented. The WHO expected new world-wide cases of cancer to grow from 11.3 million in 2007 to 15.5 million in 2030, and the number of global cancer deaths to increase from 7.9 million to 11.5 million (a 45% increase), in this same period, influenced in part by an increasing and aging global population (WHO, 2009). This literature review considers whether the use of Mindfulness-Based Cognitive Therapy (MBCT) is a promising approach for solving psychological distress among cancer patients by responding to the such as questions:

*PhD Research Scholar, Department of Psychology, Aligarh Muslim University, Aligarh, India
**Professor, Department of Psychology, Aligarh Muslim University, Aligarh, India

© 2014 F Abdollahi, M Khan; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

1. What is the Psychological distress in cancer Patients? 2. Is MBCT effective at treating psychological distress in cancer patients? 3. Is MBCT safe for cancer patients? 4. Is MBCT the best solution?

The experience of receiving a diagnosis of cancer is an intensely stressful experience for every person (Matchim & Armer, 2007), and for their family members and support system. The initial reaction to cancer diagnosis is shock and confusion. Cancer might be associated with many potentially distressing thoughts that come to patients mind such as: Why me? Did I get cancer because of something I did? Did I cause it through being stressed? Or through my lifestyle? Am I making it worse through my worry? Similarly during remission, fears of recurrence might become overwhelming. Often such questions cannot be answered and trying to resolve them can lead to extensive rumination, a style of repetitive evaluative thought that has been shown to exacerbate and maintain low mood (Watkins, 2008), including in breast cancer patients (Segerstrom, Stanton, Alden, & Shortridge, 2003). Meta-cognitive insight allows a new perspective on thinking that appears to disrupt rumination (Shapiro, Oman, Thoresen, Plante, & Flinders, 2008) and allow potentially distressing thoughts or perceptions to be experienced without overwhelming distress.

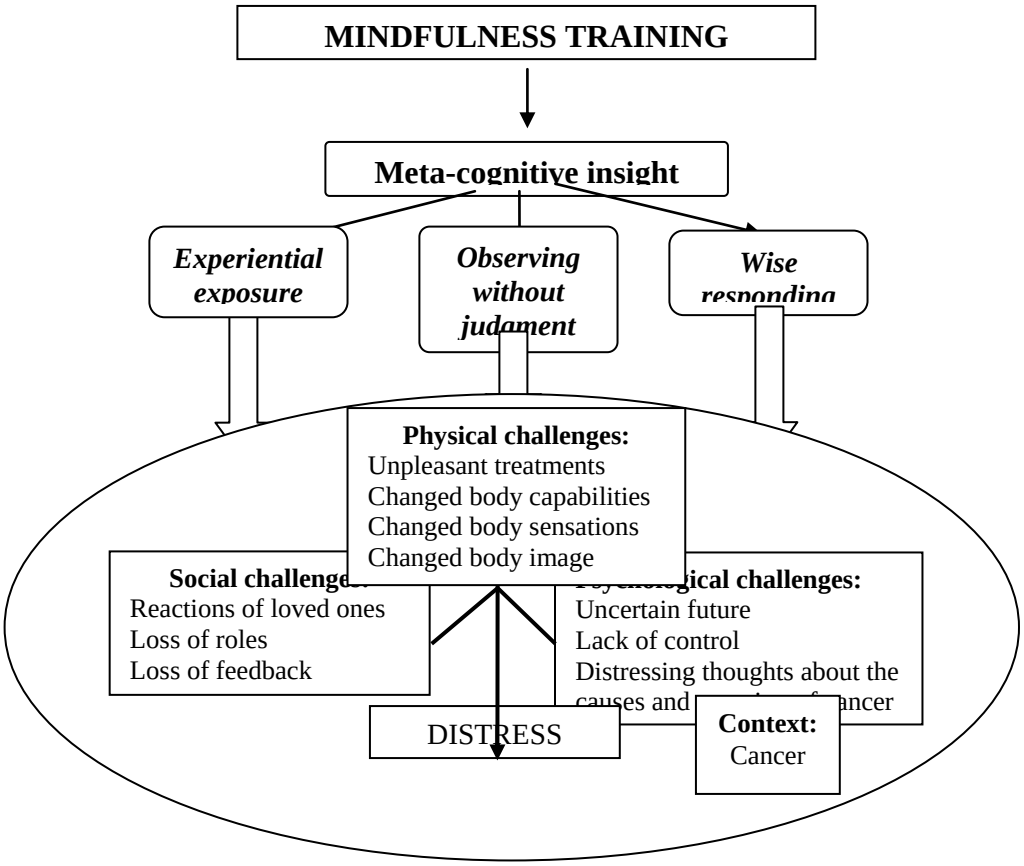


Figure 1. Diagram summarizing the challenges of cancer that might be targeted by purported mechanisms of mindfulness training (Emily Ruth Holden. 2010).

According to McGregor BA and Antoni MH (2009) cancer patients are confronted with many stressors. In addition to the excessive physiologic stress caused by the disease and its treatment, many patients experience psychological stress regarding worries about diagnosis and prognosis, demanding treatments and treatment decisions, and disruption of ordinary life functions and roles.

As a psychological support the use of mindfulness based interventions has grown exponentially across health care, and particularly in the cancer area. Mindfulness has a 3,500 year history within Buddhist tradition, and has been widely embraced within Western healthcare over the past three decades. Mindfulness has been defined as non-judgmental, present-moment awareness and is comprised of two components: (1) self-regulation of attention so that there is focus on the current experience, and (2) adoption of a curious, open, and accepting orientation to the present (Bishop, Lau, Shapiro, Carlson, Anderson, Carmody, 2004). MBCT is skills-based group was developed by Segal, Williams and Teasdale, 1995 as a successful tool to treat chronic or recurrent depressive patients. It combines elements of Cognitive Behavioral Therapy (CBT) and the practice of mindfulness meditation into an eight week program that emphasizes the internal processes of depression-related recidivism (Segal, Williams & Teasdale, 2002).

Table 1. Contrasting "Doing Mode" and "Being Mode"

Doing Mode	**Being Mode**
Goal oriented	Focus on disconnection of thought and feeling from goal-related action
Driven to reduce the gap between how things are and how we would like them to be	Focus is on "accepting" and "allowing" what is, without any immediate pressure to change it
Attention is devoted to the narrow focus on discrepancies between desired and actual states	Direct, immediate, intimate experience of the present

The diagnosis of cancer is a situation that understandably arouses a considerable amount of distress in patients. Mindfulness has been used to ease depression, anxiety and distress associated with this diagnosis (Kabat-Zinn, 2009).

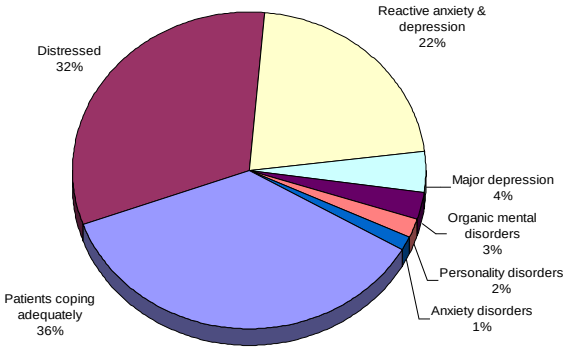
Cancer and Psychological Distress in People with Cancer

The U.S. National Center for Health Statistic described chronic disease as a disease that persists for 3 months or more, that cannot be prevented by vaccines or cured by medication and does not resolve spontaneously, cardiovascular disease, chronic respiratory disease and diabetes, now cancer ranks as a chronic disease. Health damaging behavior particularly tobacco use, lack of physical activity and poor eating habits is a major and modifiable contributor to chronic diseases (WHO, 2010; Phillips & Currow, 2010; Strong, Mathers, Leeder, Beaglehole, 2005). Cancer refers to a group of illnesses that result from cells in the body growing abnormally. These cells divide and produce new cells in an uncontrolled way that can spread throughout the body and cause damage to essential organs. Normal cells are constantly subject to signals that dictate whether the cell should divide, differentiate into another cell or die. Cancer cells develop a degree of autonomy from these signals, resulting in uncontrolled growth and proliferation. In this proliferation is allowed to continue and spread, it can be fatal. In fact almost, 90% of cancer related deaths are due to tumor spreading a process called metastasis (Momna & Ventuse, 2010).

Clinical factors such as stage and course of the disease, site of cancer, and medical and surgical treatment required have been shown to be of importance. Also, patient-related factors in the form of age-specific developmental life tasks that are threatened by the diagnosis, availability of social support and rehabilitative options have been suggested to influence psychosocial adjustment to cancer (Bottomley, 1997; Goldberg & Cullen, 1985; Holland & Rowland, 1990).

A cancer diagnosis can bring up a wide range of difficult emotions and significantly impact many areas of a person's life; it can have negative implications for psychological health, physical symptoms and may also adversely affect quality of life. Coping with a cancer diagnosis is known to be a traumatic event that can be related to declines in personal well-being and increases in distress. Effective coping is associated with a reduction of stress, depression, hopelessness or anxiety in response to a stressor. Many cancer patients experience psychological distress that distress is unlikely to be exclusively related to their disease or its treatment. Distress in cancer is defined as: "a multifactorial unpleasant emotional experience of a psychological (cognitive, behavioral, and emotional), social, and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panics, social isolation, and existential and spiritual crisis."(National Comprehensive Cancer Network [NCCN] Clinical Practice Guidelines, 2007). Coping with a cancer diagnosis is known to be a stressful experience that can be related to declines in personal well-being and increases in distress. Researchers Trish Bartley and Ursula Bates (2012) have noted that Cancer is often associated with psychological distress as showed with the help of pie-diagram.

Figure 2. Distress in oncology patients [1]



The risk of psychological distress varies between different cancer patients and at different points in the cancer journey such as: characteristics of the individual and characteristics of disease and treatment. Middelboe T and his colleagues (1994) have noted while the symptoms of psychological distress in cancer patients may closely mirror those seen in other groups their etiology, characteristics, and assessment and treatment needs may sometimes be quite different Cancer diagnosis and treatment is associated with a significant potential for psychological impact, so much in fact that some individuals will meet prevalence rate and criteria for anxiety, depression, or another mental health disorder (Van't, Trijsburg & Duivenvoorden 1997; Ott, Norris, & Bauer, 2006). Anxiety disorders occur frequently in patients

[1] Trish Bartley and Ursula Bates

with cancer compared to the general population (Bodurka et al., 2000). Another most prevalent psychological distress in advanced and terminally ill palliative cancer care patients is depression (Akechi, Okuyama, Sugawara, Shima, Furukawa & Uchitomi, 2006). Mc Daniel and his collages (1995) reported stressful life events, such as cancer diagnosis, are known to be related to increase depressive symptoms and fewer positive life experiences. According to Green AI, Austin CP (1993) depression has a biological basis in some cancers; Besides disease-related factors, lack of social support, social isolation, hopelessness and unstable financial status have also been found to contribute to the risk of depression in cancer patients (Balboni et al., 2007; Lorant, Croux, Weich, Deliege, Mackenbach, Ansseau, 2007). Feelings of hopelessness may play a special role in the distress of people with advanced cancer (Breitbart et al., 2000); and Bair MJ et al (2003) examined that some symptoms of cancer, such as pain and fatigue, demonstrate a close relationship with distress and may need to be assessed and treated concomitantly with the distress itself. Fawzy (1997) have noted that a traumatic life experience, such as the diagnosis a life- threatening illness, forces an individual to alter future plans (Fawzy & Fawzy, 1997). Having to reframe the future may result in anxiety, depression, confusion, and hopelessness. The majority of people experience anxiety and a significant degree of fear after having received a cancer diagnosis, including concerns about the future, fears about treatment side effects, changes in physical capacities, and changes in social roles (Speca, Carlson, Goodey,& Angen, 2000). An understanding of the nature of the anxiety in cancer patient populations is important because abnormal anxiety is disruptive (Sherbourne, Wells & Judd, 1996) and amenable to pharmacologic and psychological treatment (Sheard & Maguire, 1999). Brennan (2004) argues that it is the need to attend to so many simultaneous challenges in different realms (physical, psychological and social) that can be overwhelming for cancer patients and create distress. Management of symptoms related to cancer and its treatment is an important part of cancer care, affecting patient quality of life, functional status, and completion of treatment. The vast majority of cancer patients experience one or more symptoms or side effects during treatment (Barbera et al., 2010). The most common side effects are pain, fatigue, and psychological distress (Patrick et al., 2004).

MBCT Effectiveness at Treating Psychological Distress in Cancer Patients

Treatment of cancer is the series of interventions, including psychosocial support, surgery, and radiotherapy, chemotherapy that is aimed at curbing the disease or prolonging life considerably while improving the patient's quality of life (WHO, 2009).

This research was based on a psycho-educational intervention that incorporated mindfulness meditation skills which reviewed effectiveness of MBCT.

The research with the fundamental work of Zindel Segal, Mark Williams and John Teasdale (2002,2007) based on Jon Kabat-Zinn's Mindfulness-Based Stress Reduction (MBSR) program showing benefits of MBCT in the treatment of recurrent depression, stress, anxiety disorders, eating disorders, addiction and chronic illness (Kabat-Zinn, 1994; Grossman, Niemann, Schmidt

& Walach, 2004). Mindfulness-based therapeutic practices are receiving increasing empirical and clinical attention for their efficacy in treating various clinical disorders amongst a range of populations (Baer, Fischer, & Huss, 2005; Bowen et al., 2006; Evans et al., 2008; Finucane & Mercer, 2006; Ivanovski & Malhi, 2007; Kabat-Zinn, 1982; Kabat-Zinn et al., 1992; Kristeller & Hallett, 1999; Ma & Teasdale, 2004; Marlatt, 2002; Ostafin & Marlatt, 2008; Palmer & Rodger, 2009; Speca, Carlson, Goodey, & Angen, 2000; Teasdale et al., 2000; Williams, Duggan, Taylor, Crane, & Fennell, 2006; Williams et al. 2008). In the last 10 to 15 years, some studies exploring the effectiveness of MBCT in depression (Dimidjian et al., 2010; Kenny & Willimas, 2007; Ma & Teasdale, 2004; Segal et al., 2002; Teasdale et al., 2000) and anxiety (Evans et al., 2008; Williams et al., 2008) in the general population and in primary care patients with active symptoms of depression and anxiety (Finucane & Mercer, 2006). Mindfulness-based treatments have been utilized as a means to help increase an individual's awareness of emotional distress and maladaptive behavior (Baer, 2003). Mindfulness-based treatments may be helpful in treating individuals suffering from cancer (Matchim & Armer, 2007). A recent meta analysis by Piet, Wurtzen & Zachariae (2012) of 13 nonrandomized studies and 9 randomized controlled trials concluded there is positive evidence for the use of mindfulness-based interventions in reducing psychological distress in cancer patients. Research conducted by Brown and Ryan (2003) has demonstrated that trait based mindful awareness is associated with reduced psychological distress and improved well being in cancer patients. Researchers Melanie and his collages (2014) have explained, MBSR, as one of the few available psychosocial care programmes, contributes to the alleviation of lung cancer psychological distress. Findings of Stafford and colleagues (2013) provide preliminary support for the potential psychosocial benefits of MBCT in a heterogeneous group of women with cancer. Recent research shows that MBCT can effectively reduce symptoms of psychological distress in cancer patients, Sharplin et al (2010) noted the MBCT program appears to be an efficacious intervention for use among people affected by cancer that also experience symptoms of depression and anxiety. Foley and colleagues (2010) examined MBCT on outcomes of distress and quality of life among cancer patients. The intervention was modified for this population by including didactic information on cancer symptoms, making modifications for the length of the session depending on the fatigue of the individual, and including caregivers where needed. Compared to a wait-list control group, the individuals receiving MBCT showed reductions in depression, anxiety, and distress. MBCT is an effective treatment for chronic cancer-related fatigue (Lee & Garssen, 2012).

MBCT Safe for Cancer Patients

Review of literature showing the effectiveness of MBCT for a variety of issues clients face in psychological distress. A successful stress reduction treatment is MBCT, which has been found to improve both physical and mental health outcomes (Grossman, Niemann, Schmidt & Walach, 2004; Fjorback, Arendt, Ornbol, Fink & Walach, 2011). Mindfulness was originally described as a stress reduction technique (Kabat-Zinn, 1982) and studies have reported that healthy participants who are trained in mindfulness report reductions in perceived stress scores in comparison to a control group (Warnecke, Quinn, Ogden, Towle & Nelson, 2011). Mindfulness

has been reported to reduce emotional reactivity (Erisman & Roemer, 2010) and physical arousal response (Lush, Salmon, Floyd, Studts, Weissbecker & Sephton, 2009) in response to acute stress. A review of research papers concluded that mindfulness-based interventions improved immune function and distress outcomes, with a small to moderate effect size, for people with cancer (Shennan, Payne & Fenlon, 2011). Studies showed that MBSR improved the function of immune cells, displayed lower diurnal levels of blood serum cortisol and improved QoL outcomes in breast cancer patients (Shennan, 2011a, Witek-Janusek, Albuquerque, Chroniak, Chroniak, Durazo-Arvizu & Mathews, 2008). MBCT may be able to improve the function of immune cells implicated in causing cancer. Some of the mindfulness practices encourage a state of physical arousal reduction (relaxation), these states of relaxation can reduce psychological and physiological arousal. If mindfulness skills reduce the frequency with which an individual enters a state of physiological arousal. This may be a mechanism for improving physical health status (Hamilton-West, 2011). Through meditation, breathing exercises and mindful-movement practices, mindfulness-based interventions aim to teach participants to become aware of and increase flexibility to switch between different cognitive modes of mind (Williams, 2010; Westbrook, Kennerley & Kirk, 2011). While MBCT cancer groups focus on bodily sensations, this is a more significant that mindfulness exercises, such as the body scan, requiring participants to focus attention upon areas of the body affected by cancer can be challenging for some individuals also the body scan practice should proceed at a more moderate pace than in the standard classes. It is also recommended that initially the focus more general, and less specifically upon painful body sensations (Foley, Baillie, Huxter, Price & Sinclair, 2010).

The study findings suggest that MBCT is a safe program for cancer patient with psychological distress and it has psychological benefits to cancer patients.

MBCT the Best Solution

The review study on the efficacy and safety on MBCT treatments of cancer patients raise the question of whether MBCT is the best solution for reducing mitigating the psychological distress in cancer patients. MBCT is a supportive and holistic psychotherapeutic service to patients with medical illnesses and related psychological distress that may improve coping through increased sense of control, relaxation, and distraction. Whilst mindfulness-based interventions are proving effective in ameliorating existing psychological and distress they are also beginning to be used in a preventative framework, giving people the skills they need to protect themselves from developing poor psychological and emotional health (Warriner, Williams, Bardacke & Dymond, 2012).

The MBCT have clear costs for individual cancer patients, little information about long-term use, and uncertainty that they will yield significant reduction psychological distress.

CONCLUSION

In the last ten years mindfulness-based intervention has not only proven to be a feasible and acceptable intervention in cancer patients, but it also seems to be effective in reducing

psychological distress. In general, the results suggest that MBCT is an acceptable and credible treatment that was associated with significant psychological distress symptoms, quality of life and physical health improvement. MBCT could be a helpful program in a large health care system.

Psychosocial interventions that effectively reduce the burden of disease associated with cancer are a priority in cancer care. MBCT originally developed to target ruminative processes associated with relapse to distress, has recently been modified for use in oncology. MBCT is one distinct method that has been proven effective against distress, depression, anxiety, and the symptoms that go along with them. It is a structured plan that helps people be in control of their thoughts and their reactions to them and with practice can thus eliminate the body's natural but costly stress reaction responses. Mindfulness-based intervention is frequently described in psycho-oncology literature, but little is known of the effectiveness of MBCT, more research should be conducted to ensure the efficacy of this treatment in helping professions to treat impact of cancer s. Professionals, cancer patients, their families, and agencies have much to gain from further research in this field. Understanding the limitations of psychological treatments for cancer, because of their weakness highlights the complexity of the cancer problem in the world and the need for opting psycho-oncologist and scientist search for other solutions along with medical treatment.

REFERENCES

1. Akechi, T., Okuyama, T., Sugawara, Y., Shima, Y., Furukawa, T.A., Uchitomi, Y. (2006) Screening for depression in terminally ill cancer patients in Japan. *Journal of Pain Symptom Management,* 31, 5-11.
2. Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice*, 10, 125-143.
3. Baer, R., Fischer, S., & Huss, D. (2005). Mindfulness-based cognitive therapy applied to binge eating: A case study. *Cognitive and Behavioral Practice,* 12, 351-358. Retrieved from http://www.sciencedirect.com/science/journal/10777229
4. Bair, M.J., Robinson, R.L., Katon, W., Kroenke, K. (2003). Depression and pain comorbidity: a literature review. *Archives of Internal Medicine*, 163(20), 2433-2445.
5. Balboni, T.A., Vanderwerker, L.C., Block, S.D., Paulk, M.E., Lathan, C.S., Peteet, J.R., et al. (2007). Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *Journal of Clinical Oncology*, 25, 555-560.
6. Barbera L, Seow H, Howell D, et al. (2010). Symptom burden and performance status in a population-based cohort of ambulatory cancer patients. 116(24), 5767-76.
7. Bishop SR, Lau M, Shapiro S, Carlson L, Anderson ND, Carmody J. Mindfulness: A proposed operational definition.(2004). *Clin Psychol Sci Pract,* 11(3):230–41.
8. Bodurka-Bevers D, Basen-Engquist K, Carmack CL, Fitzgerald MA, Wolf JK, de Moor C, et al. (2000) . Depression, anxiety, and quality of life in patients with epithelial ovarian cancer. *Gynecol Oncol,* 78,302-308.

9. Bottomley, A. (1997). Psychosocial problems in cancer care: a brief review of common problems. *J Psychiatr Ment Health Nurs*, 4, 323-31.
10. Bowen, S., Witkiewitz, K., Dillworth, T., Chawla, N., Simpson, T., Ostafin, B., Larimer, M., Blume, A., Parks, G., & Marlatt, A. (2006). Mindfulness meditation and substance use in an incarcerated population. *Psychology of Addictive Behaviors*, 20(3), 343-347. doi: 10.1037/0893-164X.20.3.343
11. Breitbart W, Rosenfeld B, Pessin H, et al. (2000) Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer. *JAMA*, 284(22):2907-2911.
12. Brennan, J. (2004). Cancer in context. *Oxford*, Oxford University Press.
13. Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: mindfulness and its role in psychological well-being. *Journal of Personality & Social Psychology*, 84(4), 822-848.
14. Dimidjian, S., Kleiber, B., & Segal, Z. (2010). Mindfulness-based cognitive therapy. In Kazantzis, N., Reinecke, M., Dattilio, F., & Freeman, A. (Eds.), *Cognitive and Behavioral Theories in Clinical Practice* (pp. 307-330). New York: The Guilford Press.
15. Emily, R.H. (2010). Mindfulness and cancer: A literature review and empirical study *(Doctoral dissertation),* The University of Birmingham.
16. Erisman, S. M. & L. Roemer, (2010) A preliminary investigation of the effects of experimentally induced mindfulness on emotional responding to film clips. *Emotion*, 10, 72-82.
17. Evans, S., Ferrando, S., Findler, M., Stowell, C., Smart, C., & Haglin, D. (2008). Mindfulness-based cognitive therapy for generalized anxiety disorder. *Journal of Anxiety Disorders*, 22, 716-721. doi:10.1016/j.janxdis.2007.07.005
18. Fawzy, F.I. & Fawzy, N.W. (1997). Psycho educational interventions and health outcomes. In R. Glaser & J.M. Kiecolt-Glaser (Eds.), *Handbook of human stress and immunity*. San Diego, CA: Academic Press.
19. Finucane, A., & Mercer, S. (2006). An exploratory mixed methods study of the acceptability and effectiveness of mindfulness-based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry*, 6(14), 1471-244X. doi: 10.1186/1471244X-6-14
20. Finucane, A., & Mercer, S. (2006). An exploratory mixed methods study of the acceptability and effectiveness of mindfulness-based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry*, 6(14), 1471-244X. doi: 10.1186/1471244X-6-14
21. Fjorback, L. O., M. Arendt, E. Ornbol, P. Fink & H. Walach. (2011). Mindfulness-based stress reduction and mindfulness-based cognitive therapy: a systematic review of randomized controlled trials. *Acta Psychiatr Scand*, 124, 102-119.
22. Foley, E., Baillie, A., Huxter, M., Price, M., & Sinclair, E. (2010). Mindfulness-based cognitive therapy for individuals whose lives have been affected by cancer: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 78(1), 72-79.
23. Goldberg, R.J. & Cullen, L.O. (1985). Factors important to psychosocial adjustment to cancer: a review of the evidence. *Soc Sci Med*, 20, 803-7.
24. Green AI, Austin CP. Psychopathology of pancreatic cancer. (1993). *psychobiologic probe Psychosomatics*, 34:208 - 221.

25. Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of Psychosomatic Research*, 57(1), 35-43. doi:10.1016/S0022-3999(03)00573-7.
26. Hamilton-West, K., (2011) Psychobiological Processes in Health and Illness. *SAGE Publications, London.*
27. Holland, J. & Rowland, J. (1990). Handbook of psycho-oncology: Psychological care of the patient with cancer. *Oxford University Press*: New York.
28. Ivanovski, B., & Malhi, G. (2007). The psychological and neurophysiological concomitants of mindfulness forms of meditation. *Acta Neuropsychiatrica*, 19, 76–91. doi: 10.1111/j.1601 5215.2007.00175.x
29. Kabat-Zinn, J. (1982). An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. General Hospital Psychiatry, 4(1), 33-47. doi:10.1016/0163 8343(82)900275
30. Kabat-Zinn, J. (1994). Wherever you go there you are: mindfulness meditation in everyday life. *Hyperion*: New York.
31. Kabat-Zinn, J. (2009). Full catastrophe living: using the wisdom of your body and mind to face stress, pain, and illness. New York: *Delta Trade Paperbacks.*
32. Kabat-Zinn, J., Massion, A., Kristeller, J., Peterson, L., Fletcher, K., Pbert, L., Lenderking, W., & Santorelli, S. (1992). Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders. *American Journal of Psychiatry*, 149, 936-943. Retrieved from http://ajp.psychiatryonline.org/
33. Kenny, M. A., & Williams, J. G. (2007). Treatment-resistant depressed patients show a good response to Mindfulness-based Cognitive Therapy. *Behaviour Research And Therapy*, 45(3), 617-625. doi:10.1016/j.brat.2006.04.008
34. Kristeller, J., & Hallett, C. (1999). An exploratory study of a meditation-based interventionfor binge eating disorder. *Journal of Health Psychology*, 4, 357-363. doi: 10.1177/135910539900400305
35. Lee ML, Garssen B. Mindfulness-based cognitive therapy reduces chronic cancer-related fatigue: a treatment study. *Psychooncology*. 2012 Mar; 21(3):264-72. doi: 10.1002/pon.1890. Epub 2010 Dec 19. Author information: Helen Dowling Institute, Centre for Psycho-Oncology, Utrecht, The Netherlands.
36. Lorant V, Croux C, Weich S, Deliege D, Mackenbach J, Ansseau, M.(2007). Depression and socio-economic risk factors: 7-year longitudinal population study. *Brit J Psychiat*, 190:293-298.
37. Lush, E., P. Salmon, A. Floyd, J. L. Studts, I. Weissbecker & S. E. Sephton. (2009). Mindfulness meditation for symptom reduction in fibromyalgia.
38. Ma, S., & Teasdale, J., (2004). Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention efforts. *Journal of Consulting and Clinical Psychology*, 72(1), 31-40. doi: 10.1037/0022-006X.72.1.31
39. Marlatt, A. (2002). Buddhist philosophy and the treatment of addictive behavior. Cognitive and Behavioral Practice, 9, 44-50. doi:10.1016/S1077-7229(02)80039-6.

40. Matchim, Y., & Armer, J. M. (2007). Measuring the psychological impact of mindfulness meditation on health among patients with cancer: A literature review. *Oncology Nursing Forum*, 34(5), 1059-1066.
41. McDaniel, J. S., Musselman, D. L., Porter, M. R., Reed, D. A., & Nemeroff, C. B. (1995). Depression in patients with cancer: diagnosis, biology, and treatment. *Archives of General Psychiatry*, 52, 89. Retrieved from http://archpsyc.ama-assn.org
42. McGregor BA, Antoni MH.(2009). Psychological intervention and health outcomes among women treated for breast cancer: a review of stress pathways and biological mediators. *Brain Behav Immun*, 23(2):159–166
43. Melanie PJ Schellekens, Desiree GM Hurk, Judith B Prins, Johan Molema, Rogier T Donders,Willem H Woertman, Miep A Drift and Anne EM Speckens.(2014). Study protocol of a randomized controlled trial comparing Mindfulness-Based Stress Reduction with treatment as usual in reducing psychological distress in patients with lung cancer and their partners.*BMC Cancer*, 14:3, Reviewed by http://www.biomedcentral.com/1471-2407/14/3
44. Middelboe T, Ovesen L, Mortensen EL, Bech P.(1994). Depressive symptoms in cancer patients undergoing chemotherapy: a psychometric analysis. *Psychotherapy & Psychosomatics*, 61(3-4):171-177.
45. Momna Hejmadi & Ventuse.(2010). Introduction to cancer biology, *Publishing ApS*, ISBN 978-87-7681-478-6, 2010. P-6.
46. Network NCC. NCCN clinical practice guidelines in Oncology: Distress Management. (2007). http://www.nccn.org/professionals/physician_gls/PDF/distress.pdf.P6.
47. Ostafin, B., & Marlatt, A.(2008). Surfing the urge: Experiential acceptance moderates the relation between automatic alcohol motivation and hazardous drinking. *Journal of Social and Clinical Psychology*, 27(4), 404–418.
48. Ott, M. J., Norris, R. L., & Bauer-Wu, S. M. (2006). Mindfulness meditation for oncology patients: a discussion and critical review. *Integrative Cancer Therapies*, 5(2), 98-108.
49. Palmer, A., & Rodger, S. (2009). Mindfulness, stress, and coping among university students. Canadian Journal of Counseling, 43(3), 198-212. Retrieved from http://www.ucalgary.ca/ucpress/Journals.html
50. Patrick DL, Ferketich SL, Frame PS, et al. (2004). Symptom management in cancer: pain, depression, and fatigue. National Institutes of Health State-of-the-Science Conference Statement. *J Natl Cancer Inst Monogr* ,(32): 9-16.
51. Phillips JL, Currow DC. Cancer as a chronic disease. Collegian. 2010,17:47-50
52. Piet J, Wurtzen H, Zachariae R.(2012). The effect of Mindfulness-Based Therapy on symptomps of anxiety and depression in adult cancer patients and survivors: a systematic review and meta-analysis. *J Consult Clin Psychol*, 80(6):1007–1020.
53. Segal ZV, Williams JMG, Teasdale JD. (2002) Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse. New York: Guilford Press.
54. Segal, Z. V., Williams, J. M., & Teasdale, J. D. (2002). Mindfulness-based cognitive therapy for depression: a new approach to preventing relapse. New York: Guilford Press.

55. Segerstrom, S. C., Stanton, A. L., Alden, L. E., & Shortridge, B. E. (2003). A multidimensional structure for repetitive thought: What's on your mind, and how, and how much? *Journal of Personality and Social Psychology*, 85(5), 909-921.
56. Shapiro, S. L., Oman, D., Thoresen, C. E., Plante, T. G., & Flinders, T. (2008). Cultivating mindfulness: Effects on well-being. *Journal of Clinical Psychology*, 64(7), 840-862.
57. Sharplin GR, Jones SB, Hancock B, Knott VE, Bowden JA, Whitford HS. (2010). Mindfulness-based cognitive therapy: an efficacious community-based group intervention for depression and anxiety in a sample of cancer patients.. *Med J Aust*, 6;193(5 Suppl):S79-82. PMID: 21542452.
58. Sheard T, Maguire P: The effect of psychological interventions on anxiety and depression in cancer patients: Results of two meta analyses. (1999). *Br J Cancer,* 80:1770-1780, 1999.
59. Shennan, C., S. Payne & D. Fenlon, (2011) What is the evidence for the use of mindfulness-based interventions in cancer care? A review. Psychooncology 20: 681-697.
60. Sherbourne CD, Wells KB, Judd LL. (1996). Functioning and wellbeing of patients with panic disorder. *Am J Psychiatry,* 153:213-218.
61. Speca, M., Carlson, L., Goodey, E., & Angen, M. (2000). A randomized, wait-list controlled clinical trial: The effect of a mindfulness meditation-based stress reduction program on mood and symptoms of stress in cancer outpatients. *Psychosomatic Medicine,* 62, 613- 622. doi: 0033-3174/00/6205-0613
62. Stafford L, Foley E, Judd F, Gibson P, Kiropoulos L, Couper J.(2013). Mindfulness-based cognitive group therapy for women with breast and gynecologic cancer: a pilot study to determine effectiveness and feasibility. *Centre for Women's Mental Health, Royal Women's Hospital.*
63. Strong K, Mathers C, Leeder S, Beaglehole R. (2005). Preventing chronic diseases: how many lives can we save? *Lancet,* 366:1578–82.
64. Teasdale, J., Segal, Z., Williams, J., Ridgeway, V., Soulsby, J., & Lau, M. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68(4), 615-623. doi: 10.1037//0022-006X.68.4.615
65. Trish Bartley, Ursula Bates. (2011). Mindfulness-Based Cognitive Therapy for Cancer: Gently Turning Towards, Published Online: 17 NOV 2011, DOI: 10.1002/9781119960041.ch15, Copyright © 2012 Trish Bartley
66. Van't Spijker A, Trijsburg R, Duivenvoorden H.(1997). Psychological sequela of cancer diagnosis: A meta-analytical review of 58 studies after 1980. *Psychosomatic Medicine*, Vol 59(3), 280-293.
67. Warnecke, E., S. Quinn, K. Ogden, N. Towle & M. R. Nelson, (2011) A randomised controlled trial of the effects of mindfulness practice on medical student stress levels. *Med Educ* 45: 381-388.
68. Warriner, S., J. Williams, N. Bardacke & M. Dymond, (2012). A mindfulness approach to antenatal preparation. *Br. J. Midwifery*, 20: 194 - 198.
69. Watkins, E. R. (2008). Constructive and unconstructive repetitive thought. *Psychological Bulletin*, 134(2), 163-206.

70. Westbrook, D., H. Kennerley & J. Kirk, (2011) An Introduction to Cognitive Behaviour Therapy: Skills and Applications 2nd Edition. *SAGE Publications*, London.
71. Williams, J. M., (2010) Mindfulness and psychological process. *Emotion* 10: 1-7.
72. Williams, J., Alatiq, Y., Crane, C., Barnhofer, T., Fennell, M., Duggan, D., Hepburn, S., & Goodwin, G. (2008). Mindfulness-Based Cognitive Therapy (MBCT) in bipolar disorder: Preliminary evaluation of immediate effects on between-episode functioning. *Journal of Affective Disorders*, 107, 275-279. doi: 10.1016/j.jad.2007.08.022
73. Williams, J., Duggan, D., Crane, C., & Fennell, M. (2006). Mindfulness-Based Cognitive Therapy for prevention of recurrence of suicidal behaviour. *Journal of Clinical Psychology*: In Session, 62(2), 201-210. doi: 10.1002/jclp.20223
74. Williams, M., Teasdale, J., Segal, Z., Kabat-Zinn, J. (2007). The mindful way through depresession: freeing yourself from chronic unhappiness. The Guilford Press: New York
75. Witek-Janusek, L., K. Albuquerque, K. R. Chroniak, C. Chroniak, R. Durazo-Arvizu & H. L. Mathews, (2008) Effect of mindfulness based stress reduction on immune function, quality of life and coping in women newly diagnosed with early stage breast cancer. *Brain Behave Immune* 22: 969-981
76. World Health Organization. 2009. *About cause-specific mortality and morbidity*. Retrieved from http://www.who.int/features/qa/15/en/.
77. World Health Organization. 2014. *About Cancer*. Retrieved from http://www.who.int/cancer/en/.
78. World Health Organization: Chronic Diseases and Health Promotion. Accessed 20/6/2010 – http://www.who.int/chp/en/

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00236V2I12014
http://www.ijip.in | Oct to Dec 2014

Review on Psychological Test for Personnel Selection in Long Duration Mission to Extreme Environment

Dr. F. U. John Paul*

ABSTRACT:

This paper reviews literature related to the methods of personnel selection and the psychological assessment techniques for long duration missions in Antarctica and analogous environment. Drawing heavily from the current state of knowledge exemplified by various studies, this paper seeks to give an overview of some of the psychological factors pertinent to successful adaptation, and emphasizes the necessity of a standardized psychological assessment battery for use in selection of personnel for deployment to isolated and extreme environment..

Keywords: *Antarctica, extreme environment, personnel selection, psychological screening*

INTRODUCTION

It is harder to imagine the hostility of an extreme environment when human life is succumbed to the comforts of modern advancements of technological era. Nevertheless, isolated and extreme environments are still found on earth. People involved in long-duration voyages to high mountain peaks, desert islands, circumpolar regions, outer space mission, nuclear submarines, underwater laboratory and analogue environment are isolated and deployed in the most adverse environment that many consider to be hostile and unusual. Notwithstanding the risk of isolation and harsh environment, the conditions like remoteness, confinement, monotony, enforced togetherness impose several challenges for personnel in extreme environment. Therefore, the selection of personnel for deployment to such environment is a critical aspect for the success of accomplishing the missions, especially for long duration missions such as winter-over in Antarctica and long-duration spaceflight (Musson et al., 2004).

Considering the much interest these days on current fantasies about space travel and planetary exploration, the present study assumes greater significance, because it attempts to review literature dealing with selection procedures and psychological assessment techniques in personnel selection for long duration missions in Antarctica and analogous environment. Drawing heavily from the current state of knowledge exemplified by various studies, this paper seeks to give an overview of some of the psychological factors pertinent to successful adaptation, and emphasizes the necessity of a standardized psychological battery of tests for use in selection of personnel to isolated and extreme environment.

*Scientist 'C', DRDO, Air Force Selection Board, Mysore, Karnataka

© 2014 John Paul; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

Methods of Personnel Selection in Antarctic and Space mission programmes

In 1913, Shackleton, who is one of the first to be confronted with selection criteria, placed a newspaper ad that stated:

Men wanted for hazardous journey. Small wage, bitter cold, long months of complete darkness, … Safe return doubtful…. and recognition in case of success. (Taylor, 1987, p. 17).

In the early days, the leader himself chose the members for the expedition, and the members were often the people whom the leader knew personally (Smith, 1961). On examining the selection criteria for successful Antarctic winter-over of British men, Paterson (1978) adjudged the ideal candidate as introverted, reserved, trusting, intelligent, self-sufficient, independent, and forthright.

Crocq, Rivolier, and Cazes (1974) described the elaborate selection procedures for French stations. Each applicant completes medical and biographic questionnaires, followed by an interview with a psychiatrist, and completes personality and intelligence tests, followed by an interview with a psychologist. This data is then matched with the subjects' performance in the Antarctic, including medical and emotional symptoms, station leader's report, physician's report, and efficiency, to validate the selection criteria (Rothblum, 1990)

Nowadays, most countries have adopted some form of psychological screening and selection to minimize the risk of poor psychosocial adaptation and decrements in task performance. The selection procedures include formal clinical psychological or psychiatric evaluations and psychological tests (Lugg, 2005), followed by the time–tested methods of personal interviews with mission administrators and former expeditioners. Psychiatric criteria are usually used for "selecting out" individuals who are not suitable for mission because of a personality or psychiatric disorder, or who may be at high risk for such disorders (Palinkas, Johnson, Boster, 2004). Psychological criteria are usually used for "selecting in" individuals with desirable characteristics, in an attempt to predict human adaptation and performance in these environments (Santy, 1994; Kanas & Manzey, 2003).

Isolation and the life-threatening external environment are thought to be so stressful that only those with the "right stuff" could stand up to the challenge (Santy, 1994). Therefore, in the "selecting out" stage, candidates with inadequate preparation, overt psychopathology, and problematic life history are removed from further consideration. Interviews, biographical data, and tests (both objective and projective) are typically used. This screening has been emphasized because selectors view the environment as psychologically dangerous and "pathogenic" (Antonovsky, 1987).

The purpose of "selecting in" stage is to choose the best of the remaining candidates. Thus, the most challenging part of the selection process is "selecting in". To select in means identifying the applicants who are especially well suited for coping and for producing high performance in collaboration with others (Grant et al., 2007). Criteria regarding what constitutes desirability probably vary only slightly from environment to environment (Suedfeld & Steel, 2000).

A number of countries have systematic programs for selecting personnel for long-duration mission to outer space and polar expeditions. For example, Antarctica national

programmes from USA, Canada, Chile, French, New Zealand, and Australia use psychological battery of selection, while the selection panel from UK chooses to do without it (Olson, 2002, Grant et al., 2007). The British Antarctic Survey (BAS) has no psychological evaluation in selection of personnel. Instead, selection is based on the professional judgment of experienced Antarctic staff who rely on operational criteria and interviews and a general medical examination. The latter includes only the most basic mental state assessment (Grant et al., 2007). The Russian space program uses a massive array of interviews and tests, with one stress test requiring a group of candidates to drive a small car cross country, which assesses group compatibility (Suedfeld & Steel, 2000). The National Space Development Agency of Japan uses personality questionnaires, projective tests, encounter groups, participant observations, and interviews in attempting to select for positive social interaction characteristics (Santy, 1994). The winter-over Indian Antarctic expedition members undertake a battery of medical and psychological tests to qualify before the onset of expedition (John Paul et al., 2010). Unlike Antarctic national programmes, there is usually an explicit intellectual assessment in space programmes. Some psychological inventories such as NEOFFI (the "Big Five" personality inventory) and PCI (Personal Characteristics Inventory) are used in some of the Antarctic national programmes and space programmes (Steel et al., 1997; Musson et al., 2004). There is no validated psychological assessment tool for use in selection of personnel for service in Antarctica and analogous environment. It is also suggested that to include psychological inventory in the selection methods increases the chance of identifying good performers and reduces the chance of selecting poor performers (Musson et al., 2004; Grant et al., 2007).

Psychological factors related to isolation and extreme environment

Psychological adaptation to isolated, confined and extreme environment varies with factors such as personality traits, physiological characteristics, and the significant influence of environment on behavioural functioning. A number of researchers have investigated psychological factors related to the prolonged isolation and extreme envionrment. The most common symptoms associated with the austral winter in Antarctica are depression, irritability, aggressive behavior, insomnia, difficulty in concentration and memory, absentmindedness, and the occurrence of mild fugue states known as "long-eye" or the "Antarctic stare" (Palinkas et al., 1995; Palmai, 1963). For instance, during the 1989 winter season at McMurdo station, 62.1% reported feeling depressed; 47.6 % reported feeling more irritable than usual; and 51.5% reported difficulty with concentration and memory (Palinkas, 1992). Collectively, these symptoms are referred to as the "winter-over syndrome" (Strange & Youngman, 1971).

During the long winter-over periods in Antarctica, personnel have reported increases in depressive mood, psychosomatic complaints, and interpersonal conflicts, and a decrement in work performance (Bhargava et al., 2000; Ikegawa et al., 1998; Palinkas and Johnson, 1990). Likewise, there are anecdotal and behavioural evidence from space missions that crewmembers have lapses of attention, emotional liability, psychosomatic symptoms, irritability toward others, and a considerable decline in vigor and motivation (Kanas and Manzey, 2003; Suedfeld, 2005).

Nevertheless, other studies have found that isolation and confined environments are no more stressful than other environments (Suedfeld and Steel, 2000), and that high motivated and self-selected individuals who volunteer for such long-term missions are capable of maintaining high levels of performance over long periods of time (Palinkas et al., 2000)

Personnel who volunteer for long duration mission to Antarctica and Space mission programmes seem to possess common characteristics that differentiate them from people in general. Natani and Shurley (1974) found that individuals who adapt best to the Antarctic are those with good social skills who can also function in a monotonous, crowded environment without irritating their co-workers. Natani and Shurley (1974) labeled such individuals who adapt well to Antarctic living conditions as "professional isolates" (Rothblum, 1990). Succeeding the findings of several investigators, Palinkas (2003) stated that low expectations of the performance of fellow crew members and low need for social interaction are good characteristics of personnel living in isolated and confined environment.

Steel et al. (1997) observed that Antarctic expeditioners scored higher on measures of extraversion and openness to experience and lower on measures of neuroticism than population norms. In a prospective screening study of Antarctic winter-over personnel, the best performers were characterized by low levels of neuroticism (emotional liability), low desire for affection from others, low levels of boredom, low need for order, and a high tolerance for lack of achievement (Palinkas, et al., 2000). High achievement orientation and low stress reactivity have been found to be predominant characteristics in Antarctic scientists (Butcher and Ryan, 1974), and astronaut applicants at NASA (Musson et al., 2004).

On the basis of numerous reports of different expedition teams, a personality trait termed "absorption" has been identified (Atlis et al., 2004; Kahn and Leon, 1994; Leon et al., 1989). This characteristic refers to the ability to become highly engrossed in a particular activity to the exclusion of attending to other events that are happening around the person. For example, becoming so engrossed in the beauty of the Antarctic landscape that the monotony of the extensive physical exertion in a cold and windy environment is not processed as uncomfortable (Sandal, Leon, & Palinkas, 2006). This unique characteristic of engagement in the beauty of the environment or becoming highly engrossed in a particular task would likely to result in successful adaptation for an extended period of time in isolated and extreme environment.

Among established personality approaches, the "Big Five" model (Costa & McCrae, 1991) has considerable face validity for selection programs (Suedfeld & Steel, 2000). High scorers on neuroticism which is related to Gunderson's "emotional stability" dimension are clearly a select-out criterion. Whereas, high scorers on conscientiousness, related to Gunderson's "task ability" and agreeableness (Gunderson's "sociability") would clearly be favourable signs for select-in criterion (Suedfeld & Steel, 2000). The other two dimensions namely extraversion and openness to experience have mixed indicators (Suedfeld & Steel, 2000).

Standardization of psychological test for use in personnel selection

As highlighted in previous section, the wide range of psychological factors associated with isolation and extreme condition has led the researchers to use a number of psychological

inventories for evaluation of personnel in selection for deployment in isolated, confined and extreme environment. In most cases, the various psychological tests that are administered for screening an individual have no validation for use in selection of personnel to extreme environment such as space. In an attempt to validate a psychological test for use in selection of Antarctic personnel, Grant et al., (2007) developed the Selection of Antarctic Personnel (SOAP) battery which consisted of nine well-known psychological instruments. The aim of SOAP was to investigate whether standard psychological tests can predict how people actually will adapt to and cope with winter life in Antarctica. This study found no significant agreements between those actually selected by the British Antarctic Survey (BAS) panel and the selection one would have recommended based on the psychological test profiles of SOAP battery. As one of the reason for lack of significant agreement, it was stated that the interview boards based their selection on factors other than personality, social skills, and motivation, as these were not measured by the SAOP battery (Grant et al., 2007). Nevertheless, further research, in similar lines, is required for improvements in selecting out and selecting in personnel for isolated and extreme environment.

CONCLUSION

The criteria of selection process for deployment of personnel to isolated and extreme environment have been sharpened over the years so that incidences of severe psychological maladjustment and psychopathology are rare. Psychologists who are involved in selection or screening of personnel for service in isolated and extreme environment, such as Antarctica, have a large pool of potential volunteers who could manage the required technical work, yet who may have difficulty in coping with the extreme isolation and stressful living conditions. Therefore, the selection procedure must deal with important factors that are identified as unique or good characteristics of personnel living and working in isolated and extreme environment. The selection process, rather than selecting out psychopathological tendencies, should select in the desirable characteristics as suggested by several investigators. With respect to selection of personnel, there remains a need to develop a standardized psychological assessment battery for use in deployment of personnel in isolated and extreme environment. Also, research is required to develop a comprehensive psychological instrument with all personality and performance components that would optimize the select-in process.

REFERENCES

1. Antonovsky, A. (1987). *Unraveling the Mystery of Health: How people manage stress and stay well*. San Francisco: Jossey-Bass.
2. Atlis, M.M., Leon, G.R., Sandal, G.M., & Infante, M. (2004). Decision processes and interactions during a two-woman traverse of Antarctica. *Environment and Behavior*, 36, 402-423.
3. Bhargava, R., Mukerji, S., & Sachdeva, U. (2000). Psychological impact of the Antarctic winter on Indian expeditioners. *Environment and Behavior,* 32 (1), 111-27.

4. Butcher, J.N., & Ryan, M. (1974). Personality stability and adjustment to an extreme environment. *Journal of Applied Psychology*, 1, 25-44.
5. Costa, P.T. & McCrae, R.R. (1991). *Revised NEO Personality Inventory and NEO Five Factor Inventory.* Lutz, FL: Psychological Assessment Resources, Inc.
6. Crocq, L., Rivolier, J., & Cazes, G. (1974). Selection and psychological adjustment of individuals living in small isolated groups in French Antarctic stations. *Antarctic Bibliography*, 7, 228.
7. Grant, I., Eriksen, H.R., Marquis, P., Orre, I.J., Palinkas, L.A., Suedfeld, P., Svensen, E., & Ursin, H. (2007). Psychological selection of Antarctic personnel: the "SOAP" instrument. *Aviation, Space, and Environmental Medicine*, 78, 793-800.
8. Ikegawa, M., Kimura, M., Makita, K., & Itokawa, Y. (1998). Psychological studies of a Japanese winter-over group at Asuka Station, Antarctica. *Aviation, Space, and Environmental Medicine*, 69, 452-60.
9. John Paul, F.U., Mandal, M.K., Ramachandran, K., & Panwar, M.R. (2010).Cognitive performance during long-term residence in a polar environment. *Journal of Environmental Psychology*, 30, 129-132.
10. Kahn, P.M., & Leon, G.R. (1994). Group climate and individual functioning in an all women's Antarctic expedition team. *Environment and Behavior*, 26, 669-97.
11. Kanas, N., & Manzey, D. (2003). *Space psychology and psychiatry*. Kluwer Academic Press, Dodrecht.
12. Leon, G.R., McNally, C., & Ben-Porath, Y.S. (1989). Personality characteristics, mood, and coping patterns in a successful north pole expedition team. *Journal of Research Personality*, 23, 162-179.
13. Lugg, D.J. (2005). Behavioural health in Antarctica: implications for long-duration space missions. *Aviation, Space, and Environmental Medicine*, 76(Suppl), B74-B77.
14. Musson, D., Sandal, G.M., & Helmreich, R.L. (2004). Personality characteristics and trait clusters in final stage astronaut selection. *Aviation, Space, and Environmental Medicine*, 75, 342-349.
15. Natani, K., & Shurley, J.T. (1974). Sociopsychological aspects of a winter vigil at south polar station. In: Gunderson EKE, ed. *Human adaptability to Antarctic conditions.* Washington, DC: American Geophysical Union, 89-114.
16. Olson, J.J. (2002). Antarctica: A review of recent medical research. Trends in Pharmacological Sciences, 23(10), 487-490.
17. Palinkas, L.A & Johnson, J.C. (1990). Social relations and individual performance of winter-over personnel at McMurdo Station. *Antarctic Journal of the United States*, 25, 238-240.
18. Palinkas, L.A. & Browner, D. (1995). Effects of prolonged isolation on stress, coping, and depression. *Journal of Applied Social Psychology*, 25, 557-576.
19. Palinkas, L.A. (1992). Going to extremes: The cultural context of stress, illness and coping in Antarctica. *Social Science and Medicine*, 35, 651-664.

20. Palinkas, L.A. (2003). The psychology of isolated and confined environments: understanding human behaviour in Antarctica. *American Psychologist*, 58, 353-363.
21. Palinkas, L.A., Gunderson, E.K., Holland, A.W., Miller, C., & Johnson, J.C. (2000). Predictors of Behaviour and Performance in Extreme Environments: The Antarctic Space Analogous Program. *Aviation, Space, and Environmental Medicine*, 71(6), 619-25.
22. Palinkas, L.A., Johnson, J.C., & Boster, J.S. (2004). Social support and depressed mood in isolated and confined environments. *Acta Astronautica*, 54, 639-47.
23. Palmai, G. (1963). Psychological observations in an isolated group in Antarctica. *British Journal of Psychiatry*, 109, 364-370.
24. Paterson, R.A.H. (1978). Personality profiles in a group of Antarctic men. *International Review of Applied Psychology*, 27, 33-37.
25. Rothblum, E.D. (1990). Psychological factors in the Antarctic. *The Journal of Psychology*, 124 (3), 253 – 273.
26. Sandal, G.M., Leon, G.R., & Palinkas, L.A. (2006). Human challenges in polar and space environments. *Review of Environment Science Biotechnology*, 5, 281-296.
27. Santy, P.A., (1994). *Choosing the Right Stuff: The Psychological Selection of Astronauts and Cosmonauts*. London: Praeger.
28. Smith, W.M. (1961). Scientific personnel in Antarctica: Their recruitment, selection and performance. *Psychological Reports*, 9, 163-182.
29. Steel, G.D., Suedfeld, P., Peri, A., & Palinkas, L.A. (1997). People in high latitudes: the "Big Five" personality characteristics of the circumpolar sojourner. *Environment and Behavior*, 29, 324-47.
30. Strange, R.E., & Youngman, S.A. (1971). Emotional aspects of wintering over. *Antarctic Journal of the United States*, 5, 255-257.
31. Suedfeld, P. (2005). Invulnerability, coping, salutogenesis, integration: four phases of space psychology. *Aviation, Space, and Environmental Medicine*, 76, B61-B66.
32. Suedfeld, P., & Steel, G. (2000). The environmental psychology of capsule habitats. *Annual Review of Psychology*, 51, 227-253.
33. Taylor, A.J.W. (1987). *Antarctic psychology*. Wellington: Department of Scientific and Industrial Research.

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00237V2I12014
http://www.ijip.in | Oct to Dec 2014

Effect of Parental Deprivation on Self Confidence of Adolescents

Renu Tomer*, Dr. Alpna Agrawal**

ABSTRACT:

The aim of this study was to explore the effect of parental deprivation on self-confidence of adolescents. In the present study 4x2 factorial design was used. There were two independent variables, the first independent variable was parental deprivation, and distinguished at four levels that is mother deprivation, father deprivation, both deprivation and no deprivation. The second independent variable was gender distinguished at two levels that is male and female. 160 subjects (9th and 10th class) were selected for the study. Out of which 40 subjects have mother deprivation, 40 have father deprivation, 40 have both deprivation and 40 have no deprivation. In each group there were equal no of male and female. Data was collected with the help of "Agnihotri self-confidence Inventory". Obtained data were analyzed by mean, ANOVA and newman-Keuls comparison test, result reveal that parental deprivation and gender significantly affect the self-confidence of adolescents.

Keywords: *Self Confidence, Parental Deprivation*

INTRODUCTION

Self-confidence is essentially an attitude which allows us to have a positive and realistic perception of ourselves and our abilities. It is characterized by personal attributes such as assertiveness, optimism, affection, pride, independence, trust, the ability of handle criticism and Emotional maturity. Confidence is learned, it is not inherited. (**Sears, Albert 1990). Ceibb (2003)** told that "Self-confidence is the result of a successfully survived risk". **Cox, (2001)** told that "Self-confidence is a belief in yourself and or abilities, a mental attitude of transiting or relying on yourself".

The role of parents in instilling self-confidence in their children is very important. Parents who always criticize their children without acknowledging the latter strengths unknowingly dampen the development of their self-confidence, on the other hand, parents who are always willing to give support encourage their children to take a step forward will most likely rear self-confident children. Parents who make their children feel loved and accepted despite their imperfection will most likely encourage self-confidence. **Toddlers (1990)** found that when parents have high expectation, he may develop low self-confidence by the way they respond to his behaviour and choices.

*Clinical Psychologist, M.A, M.Phil, ADACP, PGDBA,Ph.D., Dept. Of Psychology, Meerut College, Meerut. & **Dept. Of Psychology, Meerut College, Meerut.

© 2014 R Tomer, A Agrawal; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

Overly strict or judgment responses can create negative effect on the self-confidence of children. The children who have low self-confidence in one or more areas do not believe that they can succeed in those areas. **Worden and Silverman (1996)** did a study on community-based sample of parentally bereaved children and composed their response to those from unattached non bereaved controls. The bereaved showed higher levels of social with-drawl, anxiety and social problems as well as lower self-confidence and self-efficacy.

In general terms self-confidence believes in you. Believing that you have what it takes to accomplish whatever you set your mind to.

METHOD

Purpose: The purpose of the present study was to study the effect of parental deprivation on self-confidence of adolescents.

Hypothesis:

1. There will be significant effect of parental deprivation on self-confidence of adolescents.
2. There will be significant effect of gender on self-confidence of adolescents.
3. There will be significant interaction effect between parental deprivation and gender on self-confidence.

Design

In the present study 4x2 factorial design was used to complete the research work. In this study there were two independent variables, the first independent variable was parental deprivation distinguished at four levels that is mother deprivation, father deprivation, both deprivation and no deprivation. The second independent variable was gender distinguished at two levels that is male and female.

Sample:

160 subjects (9^{th} and 10^{th} class) were selected for the study. Out of which 40 subjects have mother deprivation, 40 have father deprivation, 40 have both deprivation and 40 have no deprivation. In each group there were equal no of male and female.

Tool:

For the measurement of self-confidence scale constructed by "Dr. Rekha Agnihotry" 1987 was used. This scale was been prepare with 56 items. The reliability coefficient obtained by test retest and split half method. The validity coefficient obtained is .82 which is significant beyond .01 level.

Procedure:

To measure self-confidence the ASCI scale was used. After establishing good rapport with subject the ASCI scale was distributed to subjects individually. The instructions of ASCI were written in the sample form of Hindi and in the clear sense. The subjects were requested to clear

their doubts, if any. After this the inventories were taken back from all the subjects. In the end, thanks were paid to all subjects for providing their valuable time.

RESULTS:

Obtained data were analyzed with the help of mean, ANOVA and Newman-Keuls comparison test.

Summary table of ANOVA is shown in table No-1

Summary Table of ANOVA for Self-confidence Scores:

TABLE-1

Source of Variation 1	SS'	df'	MS	f-ratio
A(Parental Deprivation)	10576.87	3	3525.62	331.67**
B (Gender)	122.49	1	122.49	11.52**
AxB	302.51	3	100.84	9.48*
With in group (Error)	1615.5	152	10.63	-
Total	12617.37	159	-	-

ANOVA table indicates that F-ratio for factor A (Parental Deprivation) is 331.67 which is greater than the critical value (3.91) at 0.01 level. It suggests that parental deprivation have significant effect on self-confidence of adolescents. The second main effect of gender as an independent variable represents a comparison of the levels of self-confidence between male and females. It is evident from the ANOVA table that F-value for factor B (Gender) is 11.52 which is greater than the critical value (6.81) at 0.01 level. It suggests that self-confidence also varies according to gender. ANOVA table indicates that the F-ratio of AxB is 9.48 which is greater than the critical value (3.91) at 0.01 level. This significant interaction between parental deprivation and gender shows that these two variables are dependent on each other. Mean scores self-confidence for factor A and B are shown in Table-2.

Table-2

Group	Mean Scores
a_1 (mother deprivation)	17.75
a_2 (Father Deprivation)	17.5
a_3 (both Deprivation)	34.75
a_4 (No Deprivation)	13.75
b_1 (Male)	20.06
b_2 (Female)	21.81

Table -2 indicate that a_4 shows the lowest self-confidence scores, while a_3 shows the highest self-confidence scores. This quite clearly reveals that the subjects who have no deprivation of mother and father have the highest self-confidence while the subjects who have the deprivation of both mother and father have the lowest self-confidence. Male shows lower scores on self-confidence as compared to females. It signifies that males have high self-confidence than females

DISCUSSION AND CONCLUSION:

The purpose of the present study was to study the effect of parental deprivation and gender on self-confidence of adolescents. The first independent variable for this study was parental deprivation which was designated as 'A'. The significant F-ratio indicate that parental deprivation significantly affects the levels of self-confidence. Thus, the hypothesis that there will be significant effect of parental deprivation on self-confidence of adolescents is accepted. **Laslett (1996)** insist that parental loss has significant effect on the development of personality & self-confidence. It is the main factor of self-confidence of Individuals life. **Beals & Chaman (1991)** found that the subjects who have parental loss during childhood are more depressed, feel less satisfied, lack of self-confidence with life, struggle with relationship and have poorer physical health.

The second independent variable for this study was gender varied in two ways by using male and female. F-ratio is significant for factor B at .01 level of confidence. **Brown and Renz (2003)** found that gender significantly affects the self-confidence. It signifies that male have high self-confidence than female. **Malanie (1996)** insist that male have high self-confidence because they are more confident about their abilities to cope with problems and taken on new challenges.

In conclusion it can be said that parental deprivation significantly affects the self-confidence of adolescents. The subjects who have no deprivation of mother and father have the highest self-confidence while the subjects who have the deprivation of both mother & father have the lowest self-confidence. Males have high self-confidence than female.

REFERENCES:

1. **Basavana, M. (1975)**. Manual for self-confidence inventory Rupa Psychological Centre, Varanasi.
2. **Ceibb, J. (2003).** Self-concept of children and their intelligence achievement interest and anxiety. Retrieved May 11, 2011 http://www.kon.org.
3. **Cox, R. (2001).** Self-Concept of children and their intelligence achievement interests and anxiety. Retrieved May, 11, 2011 http://www.kon.org.
4. **Farouk, M. (2009)** Children, Concept of male & female roles. Retrieved May 10, 2011 http://www.apa.org.
5. **Laslett, P. (1996).** Advance in early education & day care. Retrieved may 10, 2001 http://www.b apa.org.
6. **Sears and Albert (1990)** The Social influence of confidence in group decision making. Retrieved May 10, 2011 http://www.apa.org.
7. **Toddlers, A. (1990).** Parental Death and Adjustment Retrieved May 12, 2011 http://www.apa.org
8. **Warden W. Silverman, R. (1996)**. Parental Death and the Adjustment of school-Age children, Retrieved May, 12, 2011 from http://www.apa.org

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00238V2I12014
http://www.ijip.in | Oct to Dec 2014

A Study of Mental Health among Patients of Cancer

Dr. Arvind Dungrani *

ABSTRACT:

This study was conducted to investigate the difference in Mental Health among Patients of cancer. Total 60 samples of Male and Female cancer patients were taken from Sir. T. General Hospital from Bhavnagar City (Gujarat). Their Samples were also taken the data was collected with the help of 'Mental Health Inventory' Developed by Dr. A. K. Shreevastav and Dr. Jagdish (1982).The Original Hindi Inventory was translated in Gujarati and Standardized by Bhava Thummar (2009). The Data was used to obtain the Mental Health measurement of the subjects. The collected data was statistically analyzed with the help of 't' test. The Results show that Mental Health for positive self Evaluation of the Male and Female Patients were not significant (t = 0.17). The Mental Health for perception of Reality of the Male and Female Patients were not significant (t = 1.34). The Mental Health for Integration of Personality of the Male and Female Patients were not significant (t = 1.74).The Mental Health for Autonomy of the Male and Female Patients were not significant (t = 0.66). The Metal Health for Group – oriented Attitude of the Male and Female Patients were not significant (t = 0.76). The Mental Health for Environmental Mastery of the Male and Female Patients were not significant (t = 0.20). The overall Mental Health of the Male and Female Patients were not significant (t = 1.25).

Keywords: *Mental health, Cancer*

INTRODUCTION

Motion is the aim of Society. Obstruction is not acceptable to it. Change is the essence element of it. Society has never remained motionless. Otherwise, its existence could not be there. But the speed and direction of change continuously change. Compared to earlier, time, today the society has become speedier. Change is taking place in each area; the said change is in both-physical area. In physical and non-physical state, the change in human psychology takes place so that mental balance is maintained. In changing time and developing always requires changing as per new situation. Change is life of all creatures.

The word 'Cancer' is derived from the word 'Cencurnm'. Its meaning is a 'Crab'. It is the most dangerous fatal disease. Cross of people in the world is suffering from the said disease (Patel-1989). Physical disease affects mental state of an individual. When a fatal disease like Cancer is diagnosed, an individual is shattered only on hearing the name of disease.

* Assoc. Prof., Shamaldas Arts College, Maharaja Krushnakumarsinhji, Bhavnagar University, Bhavnagar. (Gujarat)

© 2014 A Dungrani; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

Mental restlessness starts on hearing the name of disease only. Everybody knows that there is treatment of all these diseases. Cure is possible on undergoing treatment. Despite that, he becomes engrossed in worries on hearing only the name. The form of worry many times takes the form of death worry also.

The issue of mental health is a burning issue of modern era. The human beings will have to cultivate the art of remaining healthy in modern era, if he intends to be happy and successful. A person who is mentally healthy can know himself. He can understand difference of true and false before carrying out any work and can ascertain future results. He has self confidence in himself and can see that there is some different place of his life in the world. Lack of self confidence is found in many individuals. He believes himself to be culprit for failure in any work.

William Osler has told that: "there is good or bad effect of mental health of individual on almost all illnesses" (Supra - Bhava Thummr- 2007). Successful treatment of disease like Cancer is based on what is in mind than on the characteristics in the body of patient. As per Freud: "Mental Health means to work with sense of positive ness and love" (Supra Patel-1989). This definition is specific and meaningful. Because, it is very tough to cultivate positive approach for happening of anything in life. Similarly, to work or get it done with love without creating any hesitation is an exclusive sign of healthy mind.

As per notification of international conference on Primary Health Treatment – Alma Aata USSR 1978, 'Health' means full physical, mental and social soundness. As per notification, mental health is individual capability of establishing harmony in social and physical atmosphere. As per opinion of Schreiberm (1951), mental health means strength to go further towards logical and objective aim of individual and successful use of capability and skill for the same. Such individual experiences security and attaining honors for being associated with something. He has knowledge that others like and love him. The individual has a feeling of attaining self respect, self-reliance and something and in addition, he learns to respect others, accept them and love them and live with others peacefully.

METHODOLOGY

Hypothesis

The following things of hypothesis have been formulated for the investigation, here, researcher builds a null hypothesis.

1) We do not find any difference in Positive Self Evaluation between Male and Female Patients of Cancer.
2) We do not find any difference in Perception of Reality between Male and Female Patients of Cancer.
3) We do not find any difference in Integration of Personality between Male and Female Patients of Cancer.

4) We do not find any difference in Autonomy between Male and Female Patients of Cancer.
5) We do not find any difference in Group-Oriented Attitude between Male and Female Patients of Cancer.
6) We do not find any difference in Environmental Mastery between Male and Female Patients of Cancer.
7) We do not find any difference in Overall Mental Health between Male and Female Patients of Cancer.

Sample

60 Samples of Male and Female Patients of Cancer were randomly selected from Sir. T. General Hospital from Bhavnagar city (Gujarat). The care was taken that the socio-economic levels of all subjects remain almost the same.

Tools

For collecting the pertinent data, the following tools were used.

(a) Personal Information Schedule

The main purpose of this schedule is to collect certain pertinent data regarding the variables of the study, the various Information such as, type of Gender, Age, and level of education are collected through this schedule.

(b) Mental Health Inventory

The inventory was developed by Dr. A. K. Shreevastav and Dr. Jagdish (1982). to measure the Mental Health. Here is the information about the inventory. The original Hindi inventory was translated in Gujarati and standardized by Bhavna Thummar (2009). This inventory divided in six important areas of Mental Health in this inventory 56 questions. Each question has four options. It is sequence in this Always, Often, Some times and never to get target group has to choose any one option after data collection. It is analyzed and finds the solution.

Reliability

To decide reliability of this inventory by Dr. A. K. Shreevastav and Dr. Jagdish (1982). The reliability of Mental Health Inventory by Split-half method is r = 0.73 (N = 600).

The original Hindi inventory was translated into Gujarati by Bhavna Thummar (2009). They take 100 samples and decide the reliability of this inventory by Split-half method. To know the reliability of Dimensional Mental Health Inventory is r = 0.74

Validity

To decide validity of this inventory by Dr. A. K. Shreevastav and Dr. Jagdish (1982). The validity of Mental Health Inventory by Construct validity is r = 0.57 (N = 600).

The original Hindi Inventory was translated into Gujarati by Bhavna Thmmar (2009). While translating this inventory help of language exports and interdisplinary subject was taken according to there content in the final Mental Health Inventory prepared not only this but we applied this test on 100 samples. The validity of Mental Health inventory by Construct validity is r = 0.68. We found Correlation Significant.

Procedure

The Mental Health Inventory has six areas (1) Positive Self Evaluation (2) Perception of Reality (3) Integration of Personality (4) Autonomy (5) Group-Oriented Attitude (6) Environmental Mastery. To ask him to tick mark (✓) before the question if they agree with this Mental Health Inventory is to measure the four options, 'Always', 'Often' 'Sometimes' and 'Never'. 56 questions and Positive and Negative is Questions included in the Inventory. Positive is to be Scored 1, 2, 3 and 4. Negative is to be Scored as 4, 3, 2 and 1. The maximum is arrived at 224 and minimum score of 56 in this Inventory. It is interpreted that higher the area of value attained, the quantum of Mental Health is less and the lower the area of value attained, the quantum of Mental Health is more.

RESULT

't' value of Mental Health among Patients of Cancer follows as shown below.

Table No – 1, 't' value of Mental Health for Positive Self Evaluation between Male and Female Patients of Cancer

Group	N	M	SD	df	't' value	Level of Significant
Male	30	24.27	3.10	58	0.17	N.S.
Female	30	24.40	2.96			

N.S. = Not Significant

Table No – 2, 't' value of Mental Health for Perception of Reality between Male and Female Patients of Cancer

Group	N	M	SD	df	't' value	Level of Significant
Male	30	20.40	2.33	58	1.34	N.S.
Female	30	21.27	2.69			

N.S. = Not Significant

Table No – 3, 't' value of Mental Health for Integration of Personality between Male and Female Patients of Cancer

Group	N	M	SD	df	't' value	Level of Significant
Male	30	28.23	4.88	58	1.74	N.S.
Female	30	30.33	4.47			

N.S. = Not Significant

Table No – 4, 't' value of Mental Health for Autonomy between Male and Female Patients of Cancer

Group	N	M	SD	df	't' value	Level of Significant
Male	30	14.57	2.85	58	0.66	N.S.
Female	30	15.07	3.07			

N.S. = Not Significant

Table No – 5, 't' value of Mental Health for Group-Oriented Attitude between Male and Female Patients of Cancer

Group	N	M	SD	df	't' value	Level of Significant
Male	30	24.80	3.03	58	0.76	N.S.
Female	30	25.37	2.87			

N.S. = Not Significant

Table No – 6, 't' value of Mental Health for Environmental Mastery between Male and Female Patients of Cancer

Group	N	M	SD	df	't' value	Level of Significant
Male	30	22.83	3.31	58	0.20	N.S.
Female	30	23.03	4.41			

N.S. = Not Significant

Table No – 7, 't' value of Overall Mental Health between Male and Female

Group	N	M	SD	df	't' value	Level of Significant
Male	30	135.10	12.81	58	1.25	N.S.
Female	30	139.47	14.21			

N.S. = Not Significant

DISCUSSIONS

The chief aim of the present research was to examine Mental Health among Patients of Cancer. The derived result shows that out of seven hypotheses, while seven hypotheses have been accepted.

The difference of Positive Self-Evaluation of Mental Health between Male and Female Patients is found to be not significant. There- fore, the hypothesis is accepted. The Positive Self-Evaluation is a Part of daily life; i.e. there is no difference in Positive Self-Evolution between Male and Female Patients. The Constructive Self-Evaluation is individual's own accomplishment. This is an individual matter. Each individual must Self-Evaluate personally for himself. The said Self- Evaluation constructions are separate for male and female but there is no difference in it.

The difference of Perception of Reality of Mental Health between Male and Female Patients is found to be not significant. There fore, the hypothesis is accepted. There is no difference in perception of reality between male and female patients. Perhaps, because an individual becomes realistic for resolution of his issues. An individual thinks about true-false and loss or benefit in each situation. Simultaneously, he tries to find solution of hiss issues by making realistic evaluation of his capability to work by making his aim efforts clear and fixed. (Patel M. 1989).

The difference of Integration of Personality of Mental Health between Male and Female Patients is found to be not significant. There- fore, the hypothesis is accepted. There is no difference in Integration of Personality between Male and Female Patients. The reason is that personality is dynamic. The Personality is revolutionary. When an individual meet fatal illness, physical and behavioural changes take place in him. That too, when there is illness like Cancer, the effect of such change take place on his personality. (Vohra A. 1999)

The difference of Autonomy of Mental Health between Male and Female Patients is found to be not significant, which hypothesis is accepted, there is no difference in Autonomy between Male and Female Patients. Perhaps, the patient being an adult morally, he can become proper guide to himself. Further, there is no difference in autonomy of male and female patient. The reason may also be that the patient possesses strength to behave with proper special reaction in view of external elements working in his position. (Mathur S. S. 1985)

The difference of Group-Oriented Attitude of Mental Health between Male and Female Patients is found to be not significant, which hypothesis is accepted. There is no difference in Group-Oriented Attitude between Male and Female Patients. The constructive attitude group is the best characteristic of mental health. Here, there is no difference in attitude of both patients. Perhaps, there may be a reason behind it that the body, which was working with sufficient quantum earlier, is not working during the illness. Many times, support of others is required to be taken, for which positive attitude towards others also requires to be maintained. (Vicki S. 1996)

The difference of Environmental Mastery of Mental Health between Male and Female Patients is found to be not significant, which hypothesis is accepted. There is no difference in Environmental Mastery between Male and Female Patients. Perhaps, the patient may have idea that when an illness like Cancer has caught, the atmosphere will also have to be understood and will also have to be organized, let the said atmosphere may be family, professional, social or friend group. The social philosophy of life; i.e. social feeling, feeling of love is also very important matter. (Garrett. 1968)

The difference between overall Mental Health of Male and Female patients is found to be not significant, which hypothesis is accepted. Meaning there by that there is no difference in overall Mental Health between Male and Female Patients. The mental health is not a state of an individual. It is an aim to be attained by individual. The said aim is not attained easily and successfully. Once the said aim is attained, it is also not that the said state will maintain permanently. In dynamic world, an individual should make continuous active efforts to attain organization in his Environment.

CONCLUSIONS

1) The difference in Positive Self Evaluation between Male and Female Patients of Cancer was Not Significant.
2) The difference in Perception of Reality between Male and Female Patients of Cancer was Not Significant.
3) The difference in Integration of Personality between Male and Female Patients of Cancer was Not Significant.
4) The difference in Autonomy between Male and Female Patients of Cancer was Not Significant.
5) The difference in Group-Oriented Attitude between Male and Female Patients of Cancer was Not Significant.
6) The difference in Environmental Mastery between Male and Female Patients of Cancer was Not Significant.
7) The difference in Overall Mental Health between Male and Female Patients of Cancer was Not Significant.

REFERENCES

(1) Contractar, B.M. (1998). 1st Ed, *'Experimental Psychology theory & Statistics',* Viral Publishing, Ahemdabad, p.21.

(2) Coyne, J.C. (2010). *'Positive Psychology in Cancer Care: Bad Science, Exaggerated Claims and Unproven Medicine'*, University of Pennsylvania School of Medicine, Publish online.

(3) Garrett, H.E. (1968). 2nd Ed, *'General Psychology'*, Eurasia Publishing House, New Delhi, p.505.

(4) Kothari, S.S. (2000). *'A Study of Mental Health among Patients of T. B.'*, 17th Annual Conference Gujarat Psychology Association, Junagadh, p.33.

(5) Mathur, S.S. (2005). 2nd Ed, *'Health Psychology'*, Vinod Pustak Mandir, Agra, pp.46-61.

(6) Mathur, S.S. (1985). 1st Ed, *'Clinical Psychology'*, Vinod Pustak Mandir, Agra-2, p.256,497.

(7) Parekh, S.C. and Dixit, H. K. (1995). 1st Ed, *'A Statistical Testing In Psychological Researches'*, Chanmpa Publishing, Junagadh, p.505.

(8) Patel, M. (1989). 3rd Ed *'Abnormal Psychology',* University Book Production, Ahemdabad, p.324,558.

(9) Patel, S. (2004). 3rd Ed *'Aarogy ni Aaspas',* Indian Medical Association Morbi, pp,1-7.

(10) Schreiberm, J. (1951). *'Mental Health Flowers in Democratic Social'*, Mental Health Bulletin, Jillions Society for Mental Hygiene, pp.1-3.

(11) Shreevastav, A.K. and Jagdish, (1982). *'Mental Health Inventory'*, Agra, pp.1-9.

(12) Thummar, B.K. (2009). *'An Analytical Study of death Anxiety and Mental Health among AIDS Patients'*, M. K. Bhavnagar University, Bhavnagar, pp.258-266.

(13) Vicki, S. and Sheldon, C. (1996). *'Social Support and Adjustment To Cancer: Reconciling Descriptive, Co relational And Intervention Research'*, Health Psychology, Vol.-15 No-2, pp.135-148.

(14) Vohra, A. (1999). 1st Ed, *'Manisik Saasthy aur Manahchikitsa',* Arya Publishing, Delhi, p.19.

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00239V2I12014
http://www.ijip.in | Oct to Dec 2014

A Study of Mental Health among Patients of Tuberculosis (T.B.)

Mr. Bhavik J. Kamdar *

ABSTRACT:

This study was conducted to investigate the difference in Mental Health among Patients of Tuberculosis. Total 60 samples of Male and Female Tuberculosis patients were taken from Sir. T. General Hospital from Bhavnagar City (Gujarat). Their Samples were also taken the data was collected with the help of 'Mental Health Inventory' Developed by Dr. A. K. Shreevastav and Dr. Jagdish (1982).The Original Hindi Inventory was translated in Gujarati and Standardized by Bhava Thummar (2009). The Data was used to obtain the Mental Health measurement of the subjects. The collected data was statistically analyzed with the help of't' test. The Results show that Mental Health for positive Self- Evaluation of the Male and Female Patients were significant (t =2.00). The Mental Health for perception of Reality of the Male and Female Patients were significant (t = 2.89). The Mental Health for Integration of Personality of the Male and Female Patients were not significant (t = 0.09).The Mental Health for Autonomy of the Male and Female Patients were not significant (t =0.81). The Metal Health for Group – oriented Attitude of the Male and Female Patients were significant (t = 2.52). The Mental Health for Environmental Mastery of the Male and Female Patients were not significant (t = 1.23). The overall Mental Health of the Male and Female Patients were not significant (t = 1.49).

Keywords: *Mental health, Tuberculosis*

INTRODUCTION

Motion is the aim of Society. Obstruction is not acceptable to it. Change is the essence element of it. Society has never remained motionless. Otherwise, its existence could not be there. But the speed and direction of change continuously change. Compared to earlier, time, today the society has become speedier. Change is taking place in each area; the said change is in both-physical area. In physical and non-physical state, the change in human psychology takes place so that mental balance is maintained. In changing time and developing always requires changing as per new situation. Change is life of all creatures.

* Research Scholar, Maharaja Krushnakumarsinhji Bhavnagar University, Bhavnagar. (Gujarat)

© 2014 B Kamdar; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

What is Tuberculosis (TB)?

Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. A person with TB can die if they do not get treatment.

Tuberculosis is a bacterial disease that infects the lungs and may spread to other parts of the body. Tuberculosis has been plaguing humankind for thousands of years; it has been and still is one of the most deadly infectious diseases in the world.

The illness tuberculosis, or TB, is an infection caused by the bacterium Mycobacterium tuberculosis. These bacteria infect the body, concentrating their effects in the lungs, but they may also spread to the: --

-Brain -Bones -Kidney

-Joints -Lymph nodes -Spine

Tuberculosis Symptoms:-

The symptoms of tuberculosis are varied and often include:

-Weight loss -Night sweats

-Muscle weakness and fatigue -Phlegm or blood in cough

-Persistent cough (lasting at least three weeks) -Chest pain

-Wheezing sound when breathing -Breathing problems

Types of Tuberculosis:-

Tuberculosis can be symptomatic or inactive — you can have active tuberculosis disease with symptoms or latent tuberculosis infection.

People with latent tuberculosis infection have the bacteria in their lungs and test positive for the illness, but haven't yet experienced any symptoms. People with active tuberculosis do experience symptoms and can pass the disease to others; people with latent tuberculosis cannot infect others.

People with latent tuberculosis infection may not necessarily develop active tuberculosis, but some will.

The issue of mental health is a burning issue of modern era. The human beings will have to cultivate the art of remaining healthy in modern era, if he intends to be happy and successful. A

person who is mentally healthy can know himself. He can understand difference of true and false before carrying out any work and can ascertain future results. He has self confidence in himself and can see that there is some different place of his life in the world. Lack of self confidence is found in many individuals. He believes himself to be culprit for failure in any work.

William Osler has told that: "there is good or bad effect of mental health of individual on almost all illnesses" (Supra - Bhava Thummr- 2007). Successful treatment of disease like Tuberculosis is based on what is in mind than on the characteristics in the body of patient. As per Freud: "Mental Health means to work with sense of positive ness and love" (Supra Patel-1989). This definition is specific and meaningful. Because, it is very tough to cultivate positive approach for happening of anything in life. Similarly, to work or get it done with love without creating any hesitation is an exclusive sign of healthy mind.

As per notification of international conference on Primary Health Treatment – Alma Aata USSR 1978, 'Health' means full physical, mental and social soundness. As per notification, mental health is individual capability of establishing harmony in social and physical atmosphere. As per opinion of Schreiberm (1951), mental health means strength to go further towards logical and objective aim of individual and successful use of capability and skill for the same. Such individual experiences security and attaining honors for being associated with something. He has knowledge that others like and love him. The individual has a feeling of attaining self respect, self-reliance and something and in addition, he learns to respect others, accept them and love them and live with others peacefully.

METHODOLOGY

Hypothesis

The following things of hypothesis have been formulated for the investigation, here, researcher builds a null hypothesis.

1) We do not find any difference in Positive Self Evaluation between Male and Female Patients of Tuberculosis.
2) We do not find any difference in Perception of Reality between Male and Female Patients of Tuberculosis.
3) We do not find any difference in Integration of Personality between Male and Female Patients of Tuberculosis.
4) We do not find any difference in Autonomy between Male and Female Patients of Tuberculosis.
5) We do not find any difference in Group-Oriented Attitude between Male and Female Patients of Tuberculosis.
6) We do not find any difference in Environmental Mastery between Male and Female Patients of Tuberculosis.

7) We do not find any difference in Overall Mental Health between Male and Female Patients of Tuberculosis.

Sample

60 Samples of Male and Female Patients of Tuberculosis (TB) were randomly selected from Sir.T.General Hospital from Bhavnagar city (Gujarat). The care was taken that the socio-economic levels of all subjects remain almost the same.

Tools

For collecting the pertinent data, the following tools were used.

(a) Personal Information Schedule

The main purpose of this schedule is to collect certain pertinent data regarding the variables of the study, the various Information such as, type of Gender, Age, and level of educations are collected through this schedule.

(b) Mental Health Inventory

The inventory was developed by Dr. A. K. Shreevastav and Dr. Jagdish (1982). to measure the Mental Health. Here is the information about the inventory. The original Hindi inventory was translated in Gujarati and standardized by Bhavna Thummar (2009). This inventory divided in six important areas of Mental Health in this inventory 56 questions. Each question has four options. It is sequence in this Always, Often, Some times and never to get target group has to choose any one option after data collection. It is analyzed and finds the solution.

Reliability

To decide reliability of this inventory by Dr. A. K. Shreevastav and Dr. Jagdish (1982). The reliability of Mental Health Inventory by Split-half method is r = 0.73 (N = 600).

The original Hindi inventory was translated into Gujarati by Bhavna Thummar (2009). They take 100 samples and decide the reliability of this inventory by Split-half method. To know the reliability of Dimensional Mental Health Inventory is r = 0.74.

Validity

To decide validity of this inventory by Dr. A. K. Shreevastav and Dr. Jagdish (1982). The validity of Mental Health Inventory by Construct validity is r = 0.57 (N = 600).

The original Hindi Inventory was translated into Gujarati by Bhavna Thmmar (2009). While translating this inventory help of language exports and interdispliary subject was taken according to their content in the final Mental Health Inventory prepared not only this but we

applied this test on 100 samples. The validity of Mental Health inventory by Construct validity is r = 0.68. We found Correlation Significant.

Procedure

The Mental Health Inventory has six areas (1) Positive Self Evaluation (2) Perception of Reality (3) Integration of Personality (4) Autonomy (5) Group-Oriented Attitude (6) Environmental Mastery. To ask him to tick mark (✓) before the question if they agree with this Mental Health Inventory is to measure the four options, 'Always', 'Often' 'Sometimes' and 'Never'. 56 questions and Positive and Negative is Questions included in the Inventory. Positive is to be Scored 1, 2, 3 and 4. Negative is to be Scored as 4, 3, 2 and 1. The maximum is arrived at 224 and minimum score of 56 in this Inventory. It is interpreted that higher the area of value attained, the quantum of Mental Health is less and the lower the area of value attained, the quantum of Mental Health is more.

RESULT

't' value of Mental Health among Patients of Tuberculosis follows as shown below.

Table No – 1, 't' value of Mental Health for Positive Self Evaluation between Male and Female Patients of Tuberculosis

Group	N	M	SD	df	't' value	Level of Significant
Male	30	27.00	5.29	58	2.00	0.05
Female	30	24.60	3.91			

Table No – 2, 't' value of Mental Health for Perception of Reality between Male and Female Patients of Tuberculosis

Group	N	M	SD	df	't' value	Level of Significant
Male	30	21.13	3.38	58	2.89	0.01
Female	30	18.67	3.23			

Table No – 3, 't' value of Mental Health for Integration of Personality between Male and Female Patients of Tuberculosis

Group	N	M	SD	df	't' value	Level of Significant
Male	30	29.63	5.74	58	0.09	N.S.
Female	30	29.73	4.47			

N.S. = Not Significant

Table No – 4, 't' value of Mental Health for Autonomy between Male and Female Patients of Tuberculosis

Group	N	M	SD	df	't' value	Level of Significant
Male	30	15.83	3.07	58	0.81	N.S.
Female	30	15.33	1.59			

N.S. = Not Significant

Table No – 5, 't' value of Mental Health for Group-Oriented Attitude between Male and Female Patients of Tuberculosis

Group	N	M	SD	df	't' value	Level of Significant
Male	30	26.37	5.17	58	2.52	0.05
Female	30	23.40	3.92			

Table No – 6, 't' value of Mental Health for Environmental Mastery between Male and Female Patients of Tuberculosis

Group	N	M	SD	df	't' value	Level of Significant
Male	30	24.63	4.21	58	1.23	N.S.
Female	30	25.93	3.99			

N.S. = Not Significant

Table No – 7, 't' value of Overall Mental Health between Male and Female Patients of Tuberculosis

Group	N	M	SD	df	't' value	Level of Significant
Male	30	144.60	20.07	58	1.49	N.S.
Female	30	137.67	15.53			

N.S. = Not Significant

DISCUSSIONS

The chief aim of the present research was to examine Mental Health among Patients of Tuberculosis. The derived result shows that out of seven hypotheses, while four hypotheses have been accepted.

The difference of Positive Self-Evaluation of Mental Health between Male and Female Patients is found to be Significant. There- fore, the hypothesis is not accepted. The Positive Self-Evaluation is a Part of daily life; i.e. there is difference in Positive Self-Evolution between Male and Female Patients.

The difference of Perception of Reality of Mental Health between Male and Female Patients is found to be significant. Therefore, the hypothesis is not accepted. There is difference in perception of reality between male and female patients.

The difference of Integration of Personality of Mental Health between Male and Female Patients is found to be not significant. There- fore, the hypothesis is accepted. There is no difference in Integration of Personality between Male and Female Patients.

The difference of Autonomy of Mental Health between Male and Female Patients is found to be not significant, which hypothesis is accepted, there is no difference in Autonomy between Male and Female Patients.

The difference of Group-Oriented Attitude of Mental Health between Male and Female Patients is found to be significant, which hypothesis is not accepted. There is difference in Group-Oriented Attitude between Male and Female Patients.

The difference of Environmental Mastery of Mental Health between Male and Female Patients is found to be not significant, which hypothesis is accepted. There is no difference in Environmental Mastery between Male and Female Patients.

The difference between overall Mental Health of Male and Female patients is found to be not significant, which hypothesis is accepted. Meaning there by that there is no difference in overall Mental Health between Male and Female Patients.

CONCLUSIONS

1) The difference in Positive Self Evaluation between Male and Female Patients of Tuberculosis was Significant at 0.05 levels.
2) The difference in Perception of Reality between Male and Female Patients of Tuberculosis Significant at 0.01 levels.
3) The difference in Integration of Personality between Male and Female Patients of Tuberculosis was Not Significant.
4) The difference in Autonomy between Male and Female Patients of Tuberculosis was Not Significant**.**
5) The difference in Group-Oriented Attitude between Male and Female Patients of Tuberculosis was Significant at 0.05 levels.
6) The difference in Environmental Mastery between Male and Female Patients of Tuberculosis was Not Significant.
7) The difference in Overall Mental Health between Male and Female Patients of Tuberculosis was Not Significant.

REFERENCES

(1) Contractar, B.M. (1998). 1st Ed, *'Experimental Psychology theory & Statistics',* Viral Publishing, Ahemdabad, p.21.

(2) Garrett, H.E. (1968). 2nd Ed, *'General Psychology'*, Eurasia Publishing House, New Delhi, p.505.

(3) Kothari, S.S. (2000). *'A Study of Mental Health among Patients of T. B.'*, 17th Annual Conference Gujarat Psychology Association, Junagadh, p.33.

(4) Mathur, S.S. (2005). 2nd Ed, *'Health Psychology'*, Vinod Pustak Mandir, Agra, pp.46-61.

(5) Mathur, S.S. (1985). 1st Ed, *'Clinical Psychology'*, Vinod Pustak Mandir, Agra-2, p.256,497.

(6) Parekh, S.C. and Dixit, H. K. (1995). 1st Ed, *'A Statistical Testing In Psychological Researches'*, Chanmpa Publishing, Junagadh, p.505.

(7) Patel, M. (1989). 3rd Ed *'Abnormal Psychology',* University Book Production, Ahemdabad, p.324,558.

(8) Patel, S. (2004). 3rd Ed *'Aarogy ni Aaspas',* Indian Medical Association Morbi, pp,1-7.

(9) Schreiberm, J. (1951). *'Mental Health Flowers in Democratic Social'*, Mental Health Bulletin, Jillions Society for Mental Hygiene, pp.1-3.

(10) Shreevastav, A.K. and Jagdish, (1982). *'Mental Health Inventory'*, Agra, pp.1-9.

(11) Thummar, B.K. (2009). *'An Analytical Study of death Anxiety and Mental Health among AIDS Patients',* M. K. Bhavnagar University, Bhavnagar, pp.258-266.

(12) Vohra, A. (1999). 1st Ed, *'Manisik Saasthy aur Manahchikitsa',* Arya Publishing, Delhi, p.19.

(13) *http://www.cdc.gov/tb*

The International Journal of Indian Psychology | ISSN 2348-5396
Volume 2, Issue 1, Paper ID: B00240V2I12014
http://www.ijip.in | Oct to Dec 2014

Occupational Stress, Job Satisfaction & Mental Health among Employees of Government and Non-government Sectors

Kapildev S. Khudaniya*, Dr. S. M. Kaji**

ABSTRACT:

The purpose of the present study was to compare occupational stress, job satisfaction & mental health among employees of government and non-government sectors. In the present study the data was collected from government and non-government sectors (schools, colleges, companies & banks). A sample of 100 employees (50 government employees and 50 non-government employees) was selected randomly. The sample was equally distributed as per the gender. For this purpose of investigation "Occupational Stress Index" develop by Dr. A.K.Srivastava & Dr. A.P.Singh , Job Satisfaction Scale develop by Dr.Amar Singh & Dr. T.R.Sharma , and Employee's Mental Health Inventory develop by Dr. Jagdish were used. Data was analyzed using Mean's, SD's and t values. The finding showed that there is no significant difference in occupational stress, job satisfaction and mental health with respect to both sectors and gender. Result also showed that job satisfaction and mental health (0.149) dimensions were found positively correlated and job satisfaction (-0.186) and mental health (-0.108) were found negatively correlated with occupational stress.

Keywords: *occupational stress, job satisfaction, mental health, government, non-government, employees*

INTRODUCTION

Occupational stress is stress involving work. According to the current World Health Organization's (WHO) definition, "Occupation or work related stress's the response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope". Occupational stress nearly every one agrees that occupational stress results from the interaction of the worker and their conditions of work.

*Ph.D. Scholar, Gujarat University, Ahmadabad, Gujarat

**Associate Prof. Department of psychology, L.D. Arts College, Ahmadabad-Gujarat

© 2014 K Kudaniya, S Kaji; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

"Looking after one's mind is as important as looking after one's body"? as part of one's overall health, mental and emotional health or well being is a necessary condition to enable one to manage one's life successfully. Mental health is the emotional and spiritual resilience that allow one to enjoy life and to survive pain, suffering and disappointment, it is a positive sense of well being and a underlying belief is one's own and others dignity and worth.

Mental health is about how a person thinks feels and acts when faced with life's situations. Mental health is how people look at themselves, their lives, and the other people in their lives, evaluate their challenges and problems, and explore choices. This includes handling stress, relating to their people, and making decisions.

Job satisfaction is on attitude that employees have about their work and based on numerous factors, both intrinsic and extrinsic to the individuals. Job satisfaction is important from the retaining the appropriate employees within the organization: it is about fitting the right person to the right job in the right culture and keeping them satisfied.

L. NAHAR ET AL. (2013 investigated relationship of job satisfaction, job stress and mental health on government and non-government employees. And found job satisfaction among male employees was better than female employees but job stress and mental health found equal in both sex. Non government employees found to feel more job stress than government employees. But in job satisfaction and mental health both are equal. And mental health for the Government employee is little bit higher than non-government employee and also by sex job stress and mental health and sex was a negative relationship, but not significant.

Dr. Beulah Viji Christiana. M, & Dr. Mahalakshmi, V. (2013) Role Stress and its Impact on Public and Private Sector Managers in Chennai: An Empirical Study and found ,there is no significant difference in the stress experienced by both the public and private sector managers certain individual stressors such as work experience and educational qualifications yield differences D'Aleo, Stebbins, Lowe, Lees, and Ham (2007) examine a sample of 559 public and 105 private sector employees to assess their respective risk profiles. They find that public sector employees face more stress than private sector employees. Malik (2011) collects data on 200 bank employees in Quetta, Pakistan, of which 100 work in public sector banks and the remaining 100 in private sector banks. The author finds that there is a significant difference in the level of stress to which both groups are subject, and that public sector bank employees face a high level of occupational stress. Bushara Bano and Rajiv Kumar Jha (2012), The aim of this study is to explore the differences in job-related stress, if any, between public and private sector employees, based on ten role stressors .and found both public and private sector employees face moderate levels of stress. While there is no significant difference overall between public and private sector employees in terms of total stress levels, certain individual stressors—such as work experience and educational qualifications—do yield differences.

Abu Baker Almintisir, Abu Baker Akeel and Indra Devi Subramaniam (2012),Comparison of Job Satisfaction of Employees in Public and Private Sector Organizations: Evidence from Two Libyan Companies job satisfaction of private sector company employees is significantly higher than that of government company employees. In addition from the response of the employees from the two sector to the statement " all things considered I am very satisfied with my job" it can be seen that the private sector employees are significantly more satisfied with their jobs compared to employees from the government company ($X2 = 92.95$, $p < 0.05$)

Alam, S.& Rizvi, K (2012) psychological well-being among bank employees and found psychological well-being is higher in public sector as compared to their counterparts in private sector bank.

Lehal (2007), Studied Job Satisfaction and Organisational Role Stress in employees in Punjab and found a negative correlation between Organisational role stress and job satisfaction.

Nasurdin, Aizzat Mohd Ramayah, T Kumaresan, S (2005) in their study tried to identify the influence of organizational variables (conflict, blocked career, alienation, work over load, and unfavorable work environment) on job stress among managers and to examine whether this relationship varies according to the individual's level of neuroticism. The results of the study conveyed the fact that neuroticism was found to moderate the effects of the three organizational stressors (alienation, work overload, and unfavorable work environment) on job stress.

A. Khetarpal & G. Kochar(2006) in their study attempted to provide a preventive and positive approach to women experiencing stress at work and at home. to find out the level of role stress and to identify key role stressors, the OSI inventory by A. Krivastava was used. It was found that majority of women were under moderately low level of stress . The key stressors which affect Maximum numbers of women are Poor Peer Relations, Intrinsic Impoverishment and Under-participation.

A study conducted by LeRouge, et al (2006) concluded that role stress was positively related to both job satisfaction and organizational commitment and that self-esteem significantly moderated the relationship between role stress fit and job satisfaction.

Lewig and Dollard (2001) find that public sector employees are subject to greater work-related stress than private sector employees. Dollard and Walsh (1999), however, report that private sector workers in Queensland, Australia, had made twice as many stress claims as public sector workers. Macklin et al. (2006) survey 84 public and 143 private sector employees to assess any significant difference in their stress levels. They conclude that there is no significant difference between employees on the basis of sector, but that there is a significant difference between genders, i.e., female employees are subject to greater stress than males.

OBJECTIVES

1 To study and compare occupational stress, job satisfaction and mental health between employees of government and non-government sectors.

2 To study and compare occupational stress, job satisfaction and mental health between male and female employees

3 To study of correlation between Occupational stress, Job Satisfaction and Mental Health on employees of government and non-government sectors

HYPOTHESIS

1. There is no significant difference among type of sectors and gender with regards to their occupational stress, job satisfaction and mental health.

2. There is no significant correlation between occupational stress, job satisfaction and mental health on employees of government and non-government sectors.

METHODOLOGY

Sample

In the present study, sample was consisted of 100 employee in which 50 government sectors (25 males & 25 females) and 50 non –government sectors (25 males & 25 females) were selected randomly.

Design

Variable	Government sector	Non -government Sector	Total
Male	25	25	50
Female	25	25	50
Total	50	50	100

Tools:

Occupation stress index The Occupational Stress index (OSI) developed by Dr A.K.Srivatava and Dr. A.P. Singh was used for the study. The scale consisted of forty six items, each to rated on the five-point scale. Out of 46 items, 28 are "true keyed" and the balance 18 is "false keyed". The items related to almost all relevant components of the job life which causes stress in some way or the other such as role- overload, role-ambiguity, role conflict, group and political

pressure, responsibility for persons, under participation, powerlessness, poor peer relationship, intrinsic impoverishment, low status, strenuous working conditions and unprofitability. The reliability index ascertained by split half(odd-even) method and Cronbach's Alpha Coefficient for the scale as a whole were found to be 0.935 and 0.90 respectively. The validity of the instrument was determined by computing coefficient of correlation between the scale on the OSI and various measures of job attitudes and job behaviour.

Job Satisfaction scale:-The job satisfaction scale developed by Dr. Amar Singh & Dr. T.R. Sharma was used to measure job satisfaction. The scale has a very wide acceptance in measuring psychological aspects of functioning in any profession. It consisted 30 statements. Each to be related five point scale. The test retest reliability of the scale works out to be 0.978. The scale compares favourably with Muthayya's job satisfaction questionnaire giving a validity coefficient of 0.743

Employee's mental health:- The Employee's Mental Health Inventory (EMHI) developed by Dr. Jagdish was used for the study. The scale consisted of Twenty items, each has two response alternative, i.e. 'yes' and 'No'. the reliability of the Inventory is Reliability Coefficient 0.66, Reliability Coefficient corrected with Spearman –Brown formula 0.79 and Index of Reliability 0.89. the Validity of the instrument was determined by computing the coefficient of correlation between the score on EMHI and Mental Health Scale (Buck, 1972) and Personal Adjustment (Pestonjee, 1973). The validity coefficient was found to be 0.74 and 0.57.

PROCEDURE

The employees of Government and Non-government sectors were randomly selected & Occupational Stress Index, Job Satisfaction Scale, and Employees Mental Health Inventory were given & data was collected . The obtain data was analyzed with help of mean, SD, 't' value and correlation.

RESULT & DISCUSSION

The statistical methods used to analyze obtained data are Mean, S.D. , 't' test and Pearson Product Moment Correlation 'r' .

Table-1

Mean, standard deviation and 't' test according to Occupational stress for the types of employees/ sectors

Types of sector	N	Mean	SD	t	significant
Government	50	117.92	18.949	1.051	Non sig.
Non-government	50	122.28	22.406		

The table-1, indicates that the mean scores of occupational stress of government and Non-government employees are 117.92 and 122.28. the standard deviations for both government and non-government employees are 18.949 and 22.406 respectively. "t" value was found 1.051 which is not significant at 0.05 level. Its indicate that there is no significant difference among employees of government and non-government sector with regard to their Occupational Stress.

Table-2

Mean, standard deviation and 't' test according to Occupational stress for the Gender

Gender	N	Mean	SD	t	significant
Male	50	116.86	19.685	1.572	Non sig.
Female	50	123.34	21.496		

The table-2 indicates that the mean scores of occupational stress of male and female employees are 116.86 and 123.34. the standard deviations for both government and non-government employees are 19.685 and 21.496 respectively. "t" value was found 1.572 which is not significant at 0.05 level. Its indicate that there is no significant difference among male and female employees with regard to their Occupational Stress.

Table-3

Mean, standard deviation and 't' test according to Job satisfaction for the types of employees/ sectors

Types of sector	N	Mean	SD	t	significant
Government	50	70.82	14.439	1.272	Non sig.
Non-government	50	74.56	12.717		

The table-3, indicates that the mean scores of Job satisfaction stress of government and Non-government employees are 70.82 and 74.56. the standard deviations for both government and non-government employees are 14.439 and 12.717 respectively. "t" value was found 1.272 which is not significant at 0.05 level. Its indicate that there is no significant difference among employees of government and non-government sector with regard to their Job satisfaction.

Table-4

Mean, standard deviation and 't' test according to Job satisfaction for the Gender

Gender	N	Mean	SD	t	significant
Male	50	75.02	12.172	1.593	Non sig.
Female	50	70.36	16.731		

The table 4 indicates that the mean scores of Job satisfaction of male female employees are 75.02 and 70.36. the standard deviations for both government and non-government employees are 12.172 and 16.731 respectively. "t" value was found 1.593 which is not significant at 0.05 level. Its indicate that there is no significant difference among male and female employees with regard to their Job satisfaction.

Table-5

Mean, standard deviation and 't' test according to Mental Health for the types of employees/ sectors

Types of sector	N	Mean	SD	t	significant
Government	50	20.32	3.282	1.484	Non sig.
Non-government	50	21.2	2.607		

The table=5 indicates that the mean scores of mental health of government and Non-government employees are 20.32 and 21.20 the standard deviations for both government and non-

government employees are 3.282 and 2.607 respectively. "t" value was found 1.484 which is not significant at 0.05 level. Its indicate that there is no significant difference among employees of government and non-government sector with regard to their Occupational Stress.

Table-6

Mean, standard deviation and 't' test according to Mental Health for the Gender

Gender	N	Mean	SD	t	significant
Male	50	20.94	2.595	0.601	Non sig.
Female	50	20.58	3.341		

The table-6 indicates that the mean scores of Mental health of male and female employees are 20.94 and 20.58. The standard deviations for both government and non-government employees are 2.595 and 3.341 respectively. "t" value was found 0.601 which is not significant at 0.05 level. Its indicate that there is no significant difference among male and female employees with regard to their Job satisfaction.

Table-7

Correlation among Occupational stress, job satisfaction, and mental health of employees of government and non-government sectors

Variables	N	Mean	r
occupational stress	100	120.1	-0.185
Job satisfaction	100	72.69	
occupational stress	100	120.1	-0.108
mental health	100	20.76	
job satisfaction	100	72.69	0.149
mental health	100	20.76	

Table 7 show that there is negative correlation between occupational stress and job satisfaction on employees of government and non-government sectors.. Here also negative correlation between occupational stress and mental health on employees of government and non-government sectors . And there is positive correlation between job satisfaction and mental health on employees of government and non-government sectors, which is very low.

CONCLUSION

1. There is no significant difference among type of sectors and gender with regards to their occupational stress, job satisfaction and mental health
2. There is occupational stress negatively correlated with job satisfaction and mental health
3. There is positive correlation between job satisfaction and mental health

REFERENCES

1. Alam, S.& Rizvi, K (2012), Psychological well-being among bank employees. *Journal of the Indian accedemy of applied psychology*, vol.38, no.2, 242-247
2. Almintisir A.B ET AL (2012), Comparison of Job Satisfaction of Employees in Public and Private Sector Organizations: Evidence from Two Libyan Companies. *Australian Journal of Basic and Applied Sciences*, 6(8): 177-186, ISSN 1991-8178
3. Bano,B. and Jha,R.K. (2012),Organizational Role Stress Among Public and Private Sector Employees: A Comparative Study. *The Lahore Journal of Business*): pp. 23–36
4. Dr. Beulah Viji Christiana. M, Dr. V.Mahalakshmi(2013),*Role Stress and its Impact on Public and Private Sector Managers in Chennai: An Empirical Study*. Vol. 3, Issue 1, Jan - March 2013 ISSN : 2230-9519 (Online) | ISSN : 2231-2463 (Print)
5. Dr. Jagdish(1990),*Manual for employee's mental health inventory*. Rakhi prakashan, Agra, India
6. Dr. Singh, A. & Dr. Sharma,T.R. (1990), *Manual for job satisfaction scale*. National psychological corporation, Agra, India
7. Dr. Srivastava, A.K. & Dr. Singh, A.P. (1981), *Manual of occupational stress index. Manovagyanik parikchhan sansthan*, Varansi, India

a. http://www.ripublication.com/ijepa.htm

8. Kaur surinder(2011), Comparative Study of Occupational Stress among Teachers of Private and Govt. Schools in Relation totheir Age, Gender and Teaching Experience. *International Journal of Educational Planning & Administration* ISSN 2249-3093 Volume 1, Number 2 (2011), pp. 151-160,© Research India Publications,
9. L. NAHAR ET AL. (2013, *A investigated relationship of job satisfaction, job stress and mental health on government and non-government employees*. Psychology 2013. Vol.4, No.6, 520-525, Published Online June 2013 in SciRes (http://www.scirp.org/journal/psych)
10. Lehal, R. (2007), A Study of Organisational Role Stress and Job Satisfaction Among Executives in Punjab. *Indian Management Studies Journal*, 11, pp. 67-80
11. Macklin, D. S.,ET AL (2006), Public and private sector work stress: Workers' compensation, levels of distress and job satisfaction, and the demand-control-support model. *Australian Journal of Psychology*, *58*(3), 130–143.
12. Malik, N. (2011). A study on occupational stress experienced by private and public sector bank employees in Quetta city. *African Journal of Business Management*, *5*(8), 3063–3070.

World's #1 Indexing Partners

Edited, Printed and Published by RED'SHINE Publication. (India) Inc.
on behalf of the RED'MAGIC Networks. Inc.
86: Shradhdha, 88 Navamuvada, Lunawada, Gujarat-389230
www.redshinepub.eu.pn | info.redshine@asia.com | Co.no: +91 99 98 447091